Clayton Medical Associates, P.C.
New Patient Information

Name_____ Date of Birth_____ Date _____

Briefly describe the reason for today's visit
Who referred you to us?
Who was your last primary care doctor?

Medical History
If you have any of the following medical conditions please circle and give the approximate year you were diagnosed:

Diabetes
High Blood Pressure
High Cholesterol
Hypothyroidism or Hyperthyroidism
Migraines
Other headaches (specify)
Asthma
Chronic Obstructive Pulmonary Disorder (COPD)
Heart Disease and Heart Attacks
Peripheral Artery Disease
Vericose Vein
Blood Clots or Hemophilia
Stroke
Cancer (past or present)

Osteoarthritis
Rheumatoid Arthritis
Lupus
Other autoimmune disease
Hearing Loss
Vision Problems
Neuropathy
Chronic Diarrhea or constipation
Enlarged Prostate
Insomnia
Anxiety
Depression
Bipolar
Any other disorders (specify)

Medication Allergies (please list medication and describe type of reaction)

1)_____
2)_____
3)_____

Surgeries/Hospitalizations Year

1)_____ _____
2)_____ _____
3)_____ _____

Social History

Single Married Widowed Divorced Partnered

Occupation (past or present)_____
Children(number and ages)_____

Type of diet_____
Number of caffeinated Beverages consumed daily_____
Number of alcoholic drinks (number and frequency)_____
Are you a current or past tobacco user? Yes No
What type of tobacco and how often do you use it? _____
Have you quit? _____
Do you use any illegal drugs such as marijuana, cocaine, or heroine? Yes No Type?
Do you exercise regularly? Yes No
Are you currently sexually active? Yes No

Screening Test History (please give approximate dates if known)

Last eye exam
Last dental exam
Last colonoscopy
Last mammogram
Last chest X-Ray
Last Well Woman exam
Last Pap Smear
Last PSA/Rectal Exam
Last Bone Density DEXA
Last EKG

Immunizations (please give approximate dates if known)

Tetanus
Flu
Pneumonia
Hepatitis A
Hepatitis B
PPD (tuberculosis test)
MMR
Other

Family History

	Alive/Deceased	Age(s)	Medical Problems	Cause of Death
Mother				
Father				
Sisters				
Brothers				
Children				

Please list current medicines with dosage and frequency

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____
11)_____
12)_____

Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone:_____