* Use Black Ink Only *

HOLLEY-NAVARRE MEDICAL CLINIC

NEW PATIENT/UPDATED MEDICAL HISTORY

Completed by (signature) _____ on (date) _____

Name: _____ Date of Birth: _____

SSN: _____-_____-_____ Phone: _____ Age: _____ Gender: M F

Last Physician: _____ Last Physical: _____

Reason for Visit: _____

List Disease/Conditions that run in your family: _____

_____

List Disease/Conditions you have or have had: _____

_____

CURRENT MEDICATIONS & DOSAGES:
(Medication Name/MG/How often taken)

_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL PROBLEMS:
(Why do you take the medication?)

_____
_____
_____
_____
_____
_____
_____
_____

DRUG ALLERGIES: _____

PREFERRED PHARMACY: _____

PAST SURGERIES:
Answer YES/NO. If yes, indicate year of surgery.

Gallbladder	Y	N	_____
Hysterectomy	Y	N	_____
Appendectomy	Y	N	_____
Tonsillectomy	Y	N	_____
Other (specify)			_____

_____
_____

SOCIAL HISTORY:

Do you smoke? Y N
How Much? _____
Did you ever smoke? Y N
Date Quit? _____
Use Alcohol? Y N
How much & how often?
_____

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