CLOVIS FAMILY HEALTHCARE

New Patient Health History Form

Full Name: _____ Date: _____

Date of Birth: _____Sex: _____ Age: _____

Reason for Visit: _____ Pharmacy: _____

Previous Provider: _____

Allergies: ☐ No Known Allergies

Allergy	Reaction

Medications:

Medication	Dose	Times Per Day

Health Maintenance:

Procedure	Date	Provider/Facility	Results
Colonoscopy			**Normal/Abnormal**
Mammogram			**Normal/Abnormal**
Pap Smear			**Normal/Abnormal**
Bone Density			**Normal/Abnormal**

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Vaccine History	Date Received
Tetanus/Tdap	
Annual Flu Shot	
Zoster/Shingles	
Pneumonia/Prevnar	
COVID/Booster	

Personal History:

Condition	✓ Yes	Condition	✓ Yes
Diabetes (Type_____)		Headache/Migraine	
Alcohol or Drug Abuse		Neck/Back Problems	
Cancer (Type_____)		Rheumatoid Arthritis/Lupus	
Asthma		Osteoarthritis	
High Blood Pressure		Osteoporosis	
High Cholesterol		GERD/Heartburn	
COPD/Emphysema		Kidney/Bladder Disease	
Heart Disease		Hepatitis	
Stroke		Ulcer	
Epilepsy/Seizure		Other:	
Anemia (Type_____)		Other:	
Thyroid (Type_____)		Other:	
Depression/Anxiety/Bipolar		Other:	
Glaucoma		Other:	

Surgery (left/right)	Date	Location/Facility/Provider

Specialist	Reason/Location

Patient Name: DOB:

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Women's Health History	
Date of last Menstrual Cycle:	Age of: First Menstruation____Menopause___
Total # of Pregnancies:	Total # of Live Births:
Other:	

Social History	
Occupation:	Marital Status:
Employer:	Children: How many:
Tobacco Use: Never Current Past	Pack per Day: Year Quit: Age Started:
Alcohol Use: Never Current Past	Per Week: Liquor Beer Wine
Drug Use: Never Current Past	Which Drug:

Family History:

	Diabetes	Cancer	Cholesterol	HTN	Heart Disease	Anxiety/ Depression	Other:
Mother							
Father							
Sisters							
Brother							
Children							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

Patient Name: DOB: