

**NEW PATIENT CLINICAL INFORMATION**

**NAME:** \_\_\_\_\_

**PLEASE LIST YOUR PRIMARY CARE DOCTOR:** \_\_\_\_\_

**PLEASE LIST YOUR PHARMACY AND PHONE NUMBER:** \_\_\_\_\_

**PLEASE LIST OTHER PHYSICIANS THAT YOU ARE CURRENTLY UNDER THE CARE OF:**

\_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS AND EYE DROPS YOU ARE CURRENTLY TAKING:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY DRUG ALLERGIES:** \_\_\_\_\_

**PLEASE LIST ANY FOOD ALLERGIES:** \_\_\_\_\_

**PLEASE LIST ANY SURGERIES WITH DATES YOU HAVE HAD:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER THAN SURGERIES, PLEASE LIST ANY TREATMENTS OR HOSPITALIZATIONS, WITH DATES, YOU HAVE HAD:**

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST YOUR KNOWN MEDICAL PROBLEMS: (EX: HIGH BLOOD PRESSURE, DIABETES, ETC)**  
**CHILDHOOD:** \_\_\_\_\_

\_\_\_\_\_

**ADULTHOOD:** \_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY ILLNESS YOUR BLOOD RELATIVES HAVE HAD:**

**FATHER:** \_\_\_\_\_

**MOTHER:** \_\_\_\_\_

**BROTHER/SISTER:** \_\_\_\_\_

**AUNT/UNCLE:** \_\_\_\_\_

**GRANDPARENTS:** \_\_\_\_\_

**IF YOU SMOKE, HOW MANY PACKS PER DAY:** \_\_\_\_\_ **YEARS SMOKED:** \_\_\_\_\_

**DO YOU SMOKE CIGARS: YES/NO**    **CHEW TOBACCO: YES/NO**    **USE SNUFF: YES/NO**

**IF YOU DRINK ALCOHOL, WHAT AND HOW MUCH A DAY:**

\_\_\_\_\_

**MARTIAL STATUS: SINGLE** \_\_\_ **MARRIED** \_\_\_ **WIDOWED** \_\_\_ **DIVORCED** \_\_\_ **SEPARATED** \_\_\_

**NUMBER OF CHILDREN:** \_\_\_\_\_ **AGES:** \_\_\_\_\_

**REASON FOR DOCTORS APPOINTMENT TODAY:** \_\_\_\_\_

\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_