

**FOOTHIL FAMILY CLINIC
NEW PATIENT HEALTH HISTORY**

Today's Date ____ / ____ / ____

Name _____ Social Security # _____ Date of Birth ____ / ____ / ____

PERSONAL PROFILE:

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____

Education _____ Occupation _____

PERSONAL HABITS:

Alcohol _____ Amount _____ Tobacco _____ Amount _____ #Years _____

Recreational Drugs _____ Type _____ Amount _____

MEDICATION INFORMATION:

List All Medication You Are Now Taking

List All Medication You Are Allergic To

Surgeries & Hospitalizations:

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____

Injuries or Broken Bones:

Date:	Reason:
_____	_____
_____	_____
_____	_____

Chronic Medical Illnesses:

Family History:

Health Summary (including cause of death if deceased)

Mother's Age _____
Father's Age _____

Do you have a Living Will or Legal Power Of Attorney? Yes _____ No _____