FOOTHILL 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 ◯ Y ◉ N Amount _____ Tobacco ◯ Y ◉ N Amount _____ #Years _____

Recreational Drugs ◯ Y ◉ N Type _____ Amount _____

MEDICATION INFORMATION:

List All Medication You Are Now Taking	List All Medication You Are Allergic To
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES & HOSPITALIZATION:

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 ◉