Anderson Walk-In Clinic
New Patient History Form

Patient Name: _____ DOB:_____

Your answers on this form will help your clinician understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details.

REASON FOR VISIT:

_____

Name of primary care provider: _____

ALLERGIES or REACTIONS TO MEDICATIONS/FOODS/OTHER AGENTS:

Allergic to:	Reaction or Side Effect:

☐ No known drug allergies.

MEDICATIONS: Prescription and non-prescription medicines, vitamins, and birth control pills.

Medication	Dose	Times per Day

WHEN WAS YOUR MOST RECENT:

Tetanus Immunization: _____ Shingles Immunization: _____ Pneumonia Vaccine: _____
Mammogram: _____ Colonoscopy: _____ PAP: _____

WOMEN'S GYNECOLOGIC HISTORY:

1st day of your most recent period: _____
Is there a possibility you may be pregnant? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY:

☐ Alcoholism
☐ Abnormal Pap smear
☐ Blood disorder
☐ Cancer, type:_____
☐ Congenital heart disease
☐ Depression/Anxiety
☐ Diabetes (Type 1 – requires insulin)
☐ Diabetes (Type 2)
☐ High cholesterol
☐ Hypertension (high blood pressure)
☐ Myocardial infection (heart attack)
☐ Stroke
☐ Thyroid problem
☐ Other:_____

Patient Name: _____ DOB:_____

SURGICAL HISTORY:

Operation	Date

FAMILY HISTORY: List any of your family members that have had any of the following illnesses.

Disease	Mother	Father	Sister	Brother	Son	Daughter	Grand father	Grand mother
Alzheimer's								
Cancer								
Diabetes								
Heart Attack								
Heart Disease								
Other:_____								
Other: _____								

SOCIAL HISTORY:

Tobacco Use	Alcohol Use	Drug Use
Cigarettes Current Smoker: ☐ Yes ☐ No ☐ Never ☐ Quit, date:_____ Packs/day:_____ # of years:_____ **Other Tobacco:** ☐ Cigar ☐ Chew ☐ Pipe	Do you drink alcohol? ☐ Yes ☐ No # drinks/week:_____	Do you use any recreational drugs? ☐ Yes ☐ No If yes, what type:_____

Signature: _____ Date: _____