Junction City Medical Clinic
New Patient Information Sheet

Today's Date:_____
Name: _____
Date of Birth:_____

FAMILY HEALTH HISTORY

Father: Illnesses:_____
If deceased, cause of death_____
Mother: Illnesses:_____
If deceased, cause of death_____
Siblings: Illnesses:_____
If deceased, cause of death_____

YOUR HEALTH HISTORY

Current Medical Problems/Diagnosis:_____
_____
Previous Illnesses:_____
_____
Previous Surgeries:_____
_____
Last Colonoscopy (Approx Date and Dr's name):_____
Last Eye Exam: (Approx Date and Dr's name):_____
Tobacco Use: Current☐ Past ☐
Quantity:_____ Years:_____ Interested in Quitting:_____

Women: Last Pap Smear:_____ Last Mammogram:_____
Men: Last Prostate Exam:_____

MEDICATIONS

Please list all medications that you are currently taking (include dose and instructions):

_____
_____
_____
_____
Allergies to medications:_____