

**Junction City/Harrisburg Medical Clinic
New Patient Information Sheet**

PERSONAL INFORMATION

Today's Date _____
Name _____ Birth Date _____ Age _____ Sex _____
Address _____
street city state zip code
Home No. () _____ Work No. () _____ Cell No. () _____
Occupation _____ Single _____ Married _____ Spouse's Name _____
Referred by: _____

FAMILY HEALTH HISTORY

Father, Age _____ Illnesses _____ If deceased, cause of death _____
Mother, Age _____ Illnesses _____ If deceased, cause of death _____
Brother(s), Age(s) _____ Illnesses _____
Sister(s), Age(s) _____ Illnesses _____

YOUR HEALTH HISTORY

List below dates of any illnesses you have had:

List below dates of any surgeries you have had:

Colon Cancer Screening: No _____ Yes _____ Date _____ Last Eye Exam _____
Drinking Water Source, City, Well, Spring: _____ Allergies: _____
Tobacco Use, Type, Quantity & How Long: _____
Alcohol Use, Quantity & How Often: _____ Special Diet? _____

WOMEN-MENSTRUAL & PREGNANCY HISTORY

Last Period _____ Age at onset _____ How Often (days) _____ Duration _____
Number of pregnancies _____ Miscarriages _____ Number of living children _____
Date of Last Pap Smear _____ Date of Last Mammogram _____

MEN

Date of last PSA Test _____ Date of last Prostate Exam _____

MEDICATIONS, INCLUDE VITAMINS & HERBAL SUPPLEMENTS

