City Care Clinic

Name:

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE: Date:

1) PAST MEDICAL PROBLEMS that have required hospitalization or chronic treatment, and name/location of previous/treating doctor:

   1 4.
   2 5.
   3 6.

2) PREVIOUS SURGERIES, and where were they performed:

   1. 3.
   2. 4.

3) ALLERGIES TO MEDICATIONS:

   1. 3.
   2. 4.

4) MEDICATIONS:

   1. 3. 5.
   2. 4. 6.

5) PERSONAL/HABITS:

   - Do you smoke? Y N If yes, how many packs/day avg. and how many yrs?
   - If you have quit, when?
   - Do you drink alcohol? Y N If yes, how many drinks per week?
   - Married Single Widow(er) Divorced (circle one)
   - Employed? Y N If yes, what kind of work do you do?
   - Have you ever used recreational drugs? Y N What type?
   - Have you ever had a blood transfusion? Y N When?

6) FAMILY MEDICAL HISTORY: Has anyone in your family had any significant medical problems?

   Father: Grandparents:

   Mother: Grandparents:

   Aunts/Uncles/Siblings: