Benton Medical Clinic
New Patient Medical Information Form

PATIENT NAME: _____Date Of Birth: _____

Health Card #:_____Occupation: _____

Address: City Postal Code

_____

Telephone #: _____ Cell : _____

MALE:_____ FEMALE_____

Please list all family/household members

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Self/Family Medical History

Medical Issue	Self	Mother	Father	Siblings	GrandParents	Aunt/ Uncle
Heart Disease						
Stroke						
Blood Clot						
Cancer						
Diabetes						
Alzheimer/ Dementia						
High Blood Pressure						
Mental Health						

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Patient Name: _____

Please list ALL **MEDICAL PROBLEMS**, for which you take medication regularly for:

1. _____
2. _____
3. _____
4. _____

Please list **ANY SURGERIES** you have had in the past, along with year and where it was preformed:

1. _____
2. _____
3. _____

Please list **ALL MEDICATIONS AND SUPPLEMENTS** that you use on a regular basis: (Please indicate if none are taken)

_____

_____

_____

_____

_____

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Patient Name: _____

Please indicate **ANY ALLERGIES TO M EDICATIONS** (including antibiotics etc...)

_____

_____

_____

_____

SOCIAL HISTORY

	YES	NO	Frequency-circle the corresponding one
Smoking			Per Day
Marijuana Use			Day/Week/Month
Other Drug Use			Day/Week/Month
Alcohol			Day/Week/Month

Marital Status: _____

******PLEASE NOTE OUR OFFICE DOES NOT REFILL NARCOTICS, BENZODIAZEPINE OR CONTROLLED DRUGS******

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Consent for Communication

I understand that the office charges a fee for missed appointments, or cancellations with then 24hours notice. **Please initial** _____

Preferred Pharmacy:

_____

(Name and Location)

Proxy to receive medical information and messages:

I give permission for the office staff to leave messages regarding upcoming appointments, or to leave messages to phone back to the office for test results or other communication.

YES_____ NO_____

If yes to above, I give permission to leave messages containing medical information and instructions with the following people: (Please include translator if needed)

Name: Relationship: Phone Number:

_____

_____

In case of Emergency, please call:

Name: Relationship: Phone Number:

_____

Patient Name: _____ Date: _____

Signature: _____