NW VALLEY FAMILY MEDICAL CLINIC, INC.

21700 W Golden Triangle Rd Ste 105, Santa Clarita, CA 91326 * Tel: (661)259-9800

21119 Devonshire St, Chatsworth, CA 91311 * Tel: (818)727-1974

NAME: _____ GENDER: Male__ Female__ DATE OF BIRTH: _____
(How it is exactly printed in your insurance card.)

MARITAL STATUS: _____ RACE: _____ SS#: _____

ADDRESS: _____

TEL: Home _____ Cell: _____ Work: _____

Email: _____ Preferred Contact Method: phone____ Email ____

MEDICAL HISTORY

Please list any Medical Problem you have (past or present) and the date or year you were diagnosed:

Diagnosis:	Date/Year:	Diagnosis:	Date/Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any surgery or medical procedure(s) you had and the date when it was done:

Type of surgery/proc:	Date:	Type of surgery/proc:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please list any disease that each family member has and their age of diagnosis:

Father: _____ Mother: _____

Brother: _____ Sister: _____ Other: _____

SOCIAL HISTORY

Do you smoke? Yes ____ No ____ If yes: How many cigarettes a day? _____ Since when? _____

Do you drink alcoholic beverage? Yes ____ No ____ If yes: How much? _____ Since when? _____

Do you use any illicit drugs/Marijuana? Yes ____ No ____

MEDICATIONS

Please list all medications including Vitamins/over-the-counter ones:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Medication/Reaction: _____/_____ _____/_____ _____/_____

Food/Reaction: _____/_____ _____/_____ _____/_____

Which Pharmacy do you go to/telephone #: _____/_____