GRAVES GILBERT CLINIC
Family Care Center

Dr. Brian Macy & Dr. Lindsey Whiteman
Family Medicine and Sports Medicine
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New Patient Information

Name: _____ Date of Birth: ___/___/____ Today's Date: ___/___/____

Medical History: Please circle or list any medical condition that applies to you

diabetes	high blood pressure	high cholesterol	heart attack/blockage
previous stroke	atrial fibrillation	migraines	depression / anxiety
chronic back pain	pain management	rheumatism	under/over-active thyroid
cancer (list type)			

_____

_____

Surgical History: Please circle or list any previous surgery you have had (including the year it was done if known)

gallbladder	appendix	weight loss surgery	tonsils / adenoids removed
thyroid removed	back/neck surgery	L/R breast removed	hysterectomy / ovaries removed
knee replacement			

_____

_____

Family History: Please circle any listed health conditions that exist in these members of your family if applicable

Father:	heart attack	stroke	diabetes	cancer_____	other _____
Mother:	heart attack	stroke	diabetes	cancer_____	other _____
Brother:	heart attack	stroke	diabetes	cancer_____	other _____
Sister:	heart attack	stroke	diabetes	cancer_____	other _____

Personal History: Please circle and/or complete all that apply to you

Occupation: (former if retired or disabled): _____ Retired Disabled Student

Married: Yes to _____ No Divorced ___ time(s) Number of children: ____

Nicotine: Never smoked Current smoker ___ packs/day for ___ years Former smoker ___ packs/day for ___ years
Never used tobacco Currently: vape chew/dip ___ times per week Formerly: vape chew/dip ___ times/week

Alcohol: Never Occasionally Rarely Often: ___ drinks per week Recovering alcoholic

Medications: Please list *ALL* medications you take, including non-prescription and herbal supplements

Drug	Strength	Directions / times per day	Drug	Strength	Directions / times per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	*Additional meds written on back of page (circle this please)*		

Allergies / adverse reactions: Please list any allergy or reaction to medications OR foods that apply to you

Medication / Food / Other	Reaction (e.g., rash, swelling)	Medication / Food / Other	Reaction (e.g., rash, swelling)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	*Additional reactions written on back of page (circle this please)*	

Pharmacy: Please indicate the pharmacies to where you would like your prescriptions sent electronically

Local: _____ Mail Order: _____