Southeastern CT Primary Care, LLC &
Cloutier Family Practice, LLC
Patient History

Name: Date:

Date of Birth:

Marital Status: S M D W Children:
Occupation:

If child: Grade Extracurricular Activities/Sports:

Past Medical History: Past Surgical History:

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Last Mammogram:

Last Bone Scan:

Last Pap Smear:

Last Colonoscopy:

Last PSA (prostate specific antigen):

Vaccinations:
Tdap________Pneumonia_____________Flu_____________Other_____________

Medications: (Can provide a list to copy) Allergies:

include all OTC_daily medications _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

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Patient History

Social History:
Live with ____

Tobacco ________cigarettes/day _____packs/day for _____years if former quit date_______

Alcohol________ drinks/week

Drug use_________________

Exercise regimen____

Family History:	if living Medical History	if deceased age/cause
Father	____________________________	___________________________
	____________________________	___________________________
Mother	____________________________	___________________________
	____________________________	___________________________
Brother(s)	____________________________	___________________________
	____________________________	___________________________
Sister(s)	____________________________	___________________________
	____________________________	___________________________

Specialists:

Name	City/town/State
1.	
2.	
3.	
4.	
5.	