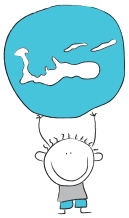

the Children's Clinic
and family practice

Windward Center, 92 Smith Road
Telephone 345-949-2970
Fax 345-946-2768
drgoffice@candw.ky
www.thechildrensclinic.ky

ADULT FORM

Name: _____ Date of Birth: _____
(Last First Middle) (Day / Month / Year)

Postal Address: _____

_____

Email: _____ Tel: _____ _____ _____
(Work) (Home) (Mobile)

Occupation/Place of Work: _____

Insurance Company: _____ Group: _____ Policy: _____

Drug or Food ALLERGIES: _____

_____

_____

Are you on medication? _____

Smoker: ❑ Yes ❑ No ❑ Ex-Smoker

Alcohol: ❑ Yes ❑ No Units/Week: _____

Family History of Illness (e.g. Asthma, Diabetes, High Blood Pressure): _____

_____

_____

Past Medical History: _____

_____

_____

Any Operations? _____

_____

_____

Any Serious Illness? _____

_____

_____

Any Chronic Health Problems? (e.g. Asthma, Diabetes, Epilepsy, Thyroid, BP): _____

_____

_____

Form Completed by (print name): _____

Signature _____ Date (D/M/Y): _____