



1125 Legacy Dr, Ste#220  
Frisco, Tx 75034  
Phone: 469.294.0210  
Fax: 469.548.7525

**New Patient Forms:**

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Phone number: \_(\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

Email: \_\_\_\_\_@\_\_\_\_\_

Preferred method of contact: SMS  Email  Phone

Preferred pharmacy name and address: \_\_\_\_\_  
\_\_\_\_\_

Please email ([info@cloverfamilymedicine.com](mailto:info@cloverfamilymedicine.com)) or text (469)294-0210 with a current photo of your driver's license and front and back of your insurance card. Please also complete a medical release form for your previous PCP, OBGYN, and any other specialists you see for us to obtain records. Please also complete the following for verification purposes:

Home Address: \_\_\_\_\_

Allergies (prescriptions): \_\_\_\_\_

Drug Intolerances: \_\_\_\_\_

Current Medical Problems: \_\_\_\_\_  
\_\_\_\_\_

Past Medical History: \_\_\_\_\_  
\_\_\_\_\_

Past Surgeries (Please include the Year):

\_\_\_\_\_

\_\_\_\_\_

Family History: **\*Please Include any/all chronic conditions\***

**Circle One:**



1. Maternal GM(Deceased/Alive): \_\_\_\_\_
2. Maternal GF (Deceased/Alive): \_\_\_\_\_
3. Paternal GM(Deceased/Alive): \_\_\_\_\_
4. Paternal GF (Deceased/Alive): \_\_\_\_\_
5. Maternal Aunt (Deceased/Alive): \_\_\_\_\_
6. Paternal Aunt (Deceased/Alive): \_\_\_\_\_
7. Maternal Uncle (Deceased/Alive): \_\_\_\_\_
8. Paternal Uncle (Deceased/Alive): \_\_\_\_\_

Social History: Please check if you do any of the following. Smoke  Alcohol  Nicotine

Caffeine Drinker: (Cups per Day) \_\_\_\_\_

Hours of Sleep per Night: \_\_\_\_\_

Occupation: \_\_\_\_\_

Diet: \_\_\_\_\_

Exercise: Cardio  Weightlifting  Pilates  **(Check One)**

Mins/Hrs Per Day of Exercise: \_\_\_\_\_

Last Colonoscopy: \_\_\_\_\_

Last Tetanus Vaccine: \_\_\_\_\_

Prescription Medications (name, strength, and frequency):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

***\*Please also bring a list of all your medications and any vitamins (with the name, strength and frequency) with you to your visit\****

Over the Counter Medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**For Women:**

Last PAP Smear: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_

Last Bone Density Scan: \_\_\_\_\_

Anything else you would like us to know about you:

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**\*For new children patients please bring vaccine records to the appointment\***