Greenville Medical Clinic

Date:_____
Name:_____

Please help us serve you better by taking a few minutes to complete this form. You may bring it with you on your first visit, or fax it in before your visit to: 864-987-4949.

Last Name: _____First Name: _____

Address: _____City: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____
(We will only use your email address to send out clinic information/updates, and appointment confirmation. No personal health information will be sent via email.)

Date of Birth: _____ Age:____ Marital Status: __S__M__D__W

Employer Name: _____ Work Phone: _____

Referred by: _____Family Physician: _____

Emergency Contact Name: _____ Phone : _____

Relationship to patient: _____

Medical History (check all that apply):

__Diabetes	__Chest Pain	__High Blood Pressure
__Constipation or Diarrhea	__High Cholesterol	__Headaches
__Heart Disease	__Sinus Disease or Allergies	__Heart attack
__Chronic pain	__Kidney Disease	__Insomnia
__Pneumonia	__Anxiety	__Seizures
__Depression	__Parkinsons	__ Arthritis
__Cancer	__Painful Urination	__Tuberculosis
__HIV	__Thyroid Disease	__Stomach Ulcer or Reflux
__Liver Disease		

Drug or food allergies (please list):
_____

Allergic to tape or latex: ____ Yes ____ No

Current Medications

Name: _____ Dose: _____ How Often: _____
Name: _____ Dose: _____ How Often: _____
Name: _____ Dose: _____ How Often: _____
Name: _____ Dose: _____ How Often: _____

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50-C Parkins Mill Road Greenville, South Carolina 29607 | Phone: 864-987-9919 Fax: 864-987-4949