1014 Oswegatchie Trail Road
Star Lake New York 13690
P: 315-848-5404
F: 315-848-2835

Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

Welcome to the Clifton Fine Primary Care Clinic

Dear New Patient,

Welcome to our practice! The following information is provided to ensure a smooth transition into our practice.

Please complete the attached forms and return prior to your scheduled appointment. Forms can be mailed to Clifton Fine Primary Care 1014 Oswegatchie Trail Road Star Lake NY 13690, Faxed to 315-848-2835, or physically dropped off. **Please note all forms must be returned prior to your scheduled appointment. Failure to submit forms will result in rescheduling of your appointment.**

If you have medical insurance, please bring an updated copy of your card and a photo ID at the time of your appointment. We ask that you try to arrive 10 minutes early to complete the registration process.

If you need to cancel/reschedule your appointments, please notify the office 24 hours in advance. ***Non-compliance with appointments or three no shows may warrant potential dismissal from the clinic.***

For any questions please call the office at 315-848-5404.

Thank you for trusting us with your care and we look forward to meeting you!

Sincerely,

The Clifton Fine Primary Care Team

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Patient Name:	Date of Birth:

Social History

Tobacco Use:
☐Never
☐Former Smoker
☐Current Smoker

If so what type;
☐Cigarettes
☐Cigar
☐Vape/E-Cigarettes
☐Chew

Start Date: _____
End Date: _____
Duration:_____
Packs Per Day:_____

Are you interested in information on smoking Cessation: Yes/No

Alcohol Use:
☐Never
☐Rare
☐Occasional
☐Every day
☐In Recovery
☐Quit
How many drinks? _____per day/week/month (circle one)

Caffeine Use:
☐Coffee ___6oz cups
☐Tea____ 6 oz cups
☐Soda____12 oz cups
☐Other _____

Exercise:
Frequency ____ times per day/week
Type of Exercise
☐Aerobic
☐Strength
☐Walking/Running
☐Other

Do you utilize any of the following (List Begin Date):
☐Oxygen | ___Liters | Consistently/As needed |Begin Date: ____
☐Cane |Begin Date: ____
☐CPAP |Begin Date: ____
☐Walker |Begin Date: ____
☐Nebulizer |Begin Date: ____
☐Shower Chair |Begin Date: ____
☐Wheelchair|Begin Date: ____

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Patient Name:	Date of Birth:

Are you interested in HIV Testing? Yes/No
Are you interested in HEP C Testing? Yes/No

SURGERIES – Please list all previous
**Include Date, Location, and Provider

TYPE OF SURGERY	DATE/LOCATION/PROVIDER

PREVENTATIVES – Have you ever had the following:

Mammogram? YES/NO	Date and Location:
Colonoscopy? YES/NO	**Date and Location:**
Bone Density Scan? YES/NO	**Date and Location:**
Low Dose Lung Cancer Screen? YES/NO	**Date and Location:**
Cervical Cancer Screening (PAP Smear)? YES/NO	**Date and Location:**

VACCINATIONS – Have you ever had the following:

COVID Vaccine? YES/NO	
Shingles Vaccine? YES/NO	**Date and Location:**
Tetanus Vaccine within last 10 years? YES/NO	**Date and Location:**
Pneumococcal Vaccine: YES/NO	**Date and Location:**

ALLERGIES (Food/Drug/Environmental):

Allergen	Reaction

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Patient Name:	Date of Birth:

MEDICATIONS (Please list all medications you take, including Over the Counter Medications).
Please bring an up to date list or pill bottles to your appointment.

Medication	Dose	Frequency

Preferred Pharmacy: _____

Do you currently see any specialty providers: YES/NO

Provider Name	Specialty	Location

FAMILY HISTORY (Please indicate family member)

☐Alcoholism:_____
☐Heart Disease:_____
☐High Blood Pressure: _____
☐Diabetes (Type 1or 2):_____
☐Stroke:_____
☐Cancer
- Breast:_____
- Colon:_____
- Skin:_____
- Lung:_____
- Prostate:_____
- Ovarian:_____

Other: _____

☐Thyroid Disease:_____
☐Depression:_____

☐Cholesterol: _____
☐Seizure Disorder:_____
☐Dementia/Alzheimer:_____
☐Parkinson's:_____
☐Mental Illness:_____
☐Osteoporosis:_____

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Patient Name:	Date of Birth:

REVIEW OF SYSTEMS (Have you had any of the following in the last 3 months? – Circle below)

Systemic: Weight change, fevers, fatigue
Head: Headache, sinus pain, Eyes: vision change, redness, pain
Neck: Pain, muscle tightness, lumps, Breast: lumps, pain, skin change
Neurological: Dizziness, fainting, confusion, numbness or tingling
Musculoskeletal: Muscle aches, joint pain, weakness
Hematological: Bruising, easy bleeding, anemia
Psychological: Depression, anxiety, trouble sleeping
Genitourinary: Change in urine, incontinence, genital discharge
Gastrointestinal: Vomiting, diarrhea, constipation, blood in stool, stomach pain
Cardiovascular: Chest pain, racing heart, fainting, palpitations
Pulmonary: Shortness of breath, wheezing, cough
Ears/Nose/Throat: Sore throat, stuffy nose, snoring, sneezing
Endocrine: Excessive thirst, hair loss, excessive sweating
Skin: Rash, itching, sores

PAST MEDICAL HISTORY (Please select the boxes that apply to you)?

- ☐ADHD
- ☐Adrenal Disorder
- ☐A-Fib
- ☐Anemia
- ☐Arthritis
- ☐Asthma
- ☐Bleeding Disorder
- ☐Blood Clot
- ☐Cancer
- ☐Celiac Disease
- ☐Chicken Pox
- ☐COPD
- ☐Crohn's Disease
- ☐Depression
- ☐Diabetes
  - ➢ Type 1 or 2
- ☐Diverticulosis
- ☐Eczema
- ☐Edema
- ☐Epilepsy
- ☐Fibromyalgia
- ☐Gout
- ☐Heart Attack
- ☐Heart Disease/ CHF
- ☐Heart Murmur
- ☐Hemorrhoids
- ☐Hepatitis
- ☐Hernia
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐HIV/AIDS
- ☐Kidney disease
- ☐Kidney Stone
- ☐Lung Disease
- ☐Lyme disease
- ☐Malaria
- ☐Measles
- ☐Migraines
- ☐Multiple Sclerosis
- ☐Mumps
- ☐Neuropathy
- ☐Osteoporosis
- ☐Polio
- ☐Psoriasis
- ☐Reflux Disease/ GERD
- ☐Rheumatic Fever
- ☐Rheumatoid Arthritis
- ☐Seizures
- ☐Skin Disorder
- ☐Stroke
- ☐Thyroid: Hyper/Hypo
- ☐Tuberculosis
- ☐Ulcer
- ☐Pacemaker
- ☐Goiter
- ☐Other (Specify)

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NEW PATIENT PACKET