FLORIDA DIABETES & ENDOCRINE ASSOCIATES

NEW PATIENT MEDICAL HISTORY FORM

Name: _____DOB_____/_____/_____

REASON FOR VISIT TODAY:_____

Primary Care Provider/Referring Provider_____ Phone #_____

MEDICATION LIST (use separate page if needed):

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

ALLERGIES/SIDE EFFECTS:

MEDICATION ALLERGY	REACTION/SIDE EFFECTS

SOCIAL HISTORY (CIRCLE ONE)

TOBACCO USE: __YES or NO or FORMER_ CIGAR/TOBACCO/CIGARETTES ____Packs/day _____Years
Date Quit: _____

ALCOHOL USE: __YES or NO or FORMER_ Type:_____ Amount:_____ Frequency:_____

RECREATIONAL DRUG USE: _____

Patient signature: _____ Date: _____

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