FIRST CHOICE MEDIAL CARE, PLLC

PATIENT DATA FORM

Name:________________________DOB:________Home Phone:__________Date:

ALLERGIES: ____

(DATE All SUBSEQUENT CHANGES **TO** HISTORY)

Family History

M_____________
F______________
Bro ______________
Sis_____________
____
____
____

Social History 0nclude Substance Abuse) _

Tob _ _ _ _ _ _ _ _
EtOH ______________
____
M/D/W/S____ _
_ Children____ _
Emply _____________

Surgeries/Dates:

____
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____
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____
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Past Medical History:

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PHARMACY	For patients over the age 18:
	Do you have an advance directive:
Pain Management Agreement?	__ No Yes
__ No __ Yes	Would you like printed information?
	__ No __ Yes

CHRONIC MEDICATION LIST

Start Date	Medication Freq./Dosage	Initials	Start Date	Medication Freq./Dosage	Initials

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