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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Past Medical History:

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

CHRONIC MEDICATION LIST

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