Midori Med

New Patient Intake

Welcome to Med420fl. Please take time to fill out this form prior to your visit. The more information that you provide on this form will allow us the provide you more detailed and faster office visit. You may have the opportunity to fill this information directly into your medical record through our online portal.

Date: _____ Email Address: _____

Name: _____ Sex: Male____ Female____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (H)_____ (W)_____ (M)_____

Marital Status: ____ Married ____ Divorced/Separated ____Widow ____Single_____

Emergency Contact Name/Relationship_____ Phone _____

Race: Check one
___Native America ___Black or African American ___Middle Eastern ___Asian ___Hispanic/Latino
___Hawaiian/Pacific Island ___White/Caucasian ___Other_____

Primary language: Check One
___English ___Spanish ___French ___Arabic ___Portuguese ___Chinese ___ Other_____

Primary Care Physician Name: _____ Phone: _____
Address: _____ City/FL/Zip_____

Other Treating Physician Name: _____ Phone: _____
Address: _____ City/FL/Zip: _____

Past Medical History/Qualifying Condition (Check all that apply):
___ALS/Lou Gehrig's Disease ___AIDS/HIV ___Cancer ___Epilepsy/Seizures
___Crohn's Disease ___Glaucoma ___Muscle Cramps/Pain ___ Parkinson's Disease
___MS/Multiple Sclerosis ___Chronic pain ___PTSD ___ Other_____

Are You Pregnant? Yes___ No___
Are you taking any controlled substances? Yes___ No___ [The state of Florida requires that we review all patients controlled substance use history on the state database]

Medications: Please list all medication you are presently taking

_____ _____ _____

_____ _____ _____

Social History:

Tobacco/Smoke ___ No ____Yes _____pack per day _____ years
Alcohol: ____ No _____ Yes _____ drinks per day _____ years
Illicit drug use ___ No ____ Yes (drugs used) _____ Stopped when _____

Pertinent Family History

___ Heart Disease/ Hypertension ____ Stroke/ CVA ____ Lung Disease [Asthma, COPD]
___ Cancer (type)_____ Blood Disorder ____ Neurologic Disease
___ GI/ Abdominal (Liver, Spleen, Pancreas) ___ Urinary/Bladder ___ Diabetes
___ Ear/Nose ___ Vision

Drug Allergies ___no ___ yes; what drugs_____
Allergy type _____

Food Allergies: ___no ___ yes; what foods_____
Allergy type_____

Surgical History: ___ No ____ yes; please explain what type of surgery and date below

_____ Date_____
_____ Date_____
_____ Date_____
_____ Date _____