East Valley Diabetes &
Endocrinology
P: 480-782-9531 F: 480-782-9530
myazdr.com

Patient Name: _____ Date of Birth: _____/_____/_____ Phone: (_____)_____-_____

Medications (Please list all you're currently taking): ___ Copy of medication list attached

Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____
Name:_____ Strength:_____

Personal medical history:

Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Surgery/Procedure: _____ Date: _____
Surgery/Procedure: _____ Date: _____
Surgery/Procedure: _____ Date: _____
Surgery/Procedure: _____ Date: _____

Previous medical diagnoses/symptoms (if applicable):

_____
_____
_____
_____

Family medical history (Mother/Father/Siblings):

_____
_____
_____
_____

Tobacco use? ___Yes ___No

PLEASE TAKE THIS INTO THE ROOM WITH YOU