



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