



Florida Medical Clinic, PA
Barkat U. Khan, M.D.
6719 Gall Blvd., Suite 207
Zephyrhills, FL 33542

Patient's Personal History & Assessment

Date: _____

Name: _____ Date of Birth: _____

Describe briefly why you are seeking treatment:

Who were you referred by: _____

Have you had previous psychiatric treatment? Yes _____ No _____

If yes, when and where? _____

SOCIAL HISTORY:

Occupation: _____ Are you retired? Yes _ No _ Disabled, _____

Marital History: Single_ Married_ Divorced_ Separated_ Widowed_

Do you: Live alone_ Live with spouse_ live with parents_

PERSONAL HABITS:

Have you ever smoked? Yes _____ No _____ Do you currently smoke? Yes _____ No _____

Check if you regularly drink:

Hard liquor: 1-3oz per day _____ Over 3oz per day _____

Beer: 1 bottle per day _____ 2 bottles a day _____ 3 or more a day _____

Have you ever used any of the following?

Marijuana: _____ LSD: _____ Heroin: _____ Cocaine: _____ Speed: _____ Other: _____

If so, are you currently using? Yes _____ No _____ If yes, what are you using: _____

EDUCATION:

What is the highest grade you completed? _____

MEDICAL CONDITIONS:

List all medical diagnosis:



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Name: _____ Date of Birth: _____

MEDICATIONS:

Do you have any allergies? Yes ___ No ___

If yes, what: _____

What medications are you currently taking?

Name:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy Name: _____ Number: _____