Florida Medical Clinic, LLC
6719 Gall Blvd.
Zephyrhills, FL 33542

Suite 207
Barkat U. Khan, M.D.
Rita Morgan, APRN

Suite 204
Sujal Kotadia, M.D.
Nusrat Bangash, APRN
Felicia Seal, LCSW

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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Continue →

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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: ____________________________