Dr. Linda Marraccini/ Dr. John Marraccini

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Phone: (305) 666-8858
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DATE: ____/____/____

NAME: _____ D.O.B _____/_____/_____

- **Have you traveled in the last 2 weeks? YES or NO**
- **Have you had any fever or chills in the past two weeks? YES or NO**
- **Do you have any cold symptoms? YES or NO**
  - **What symptoms? /How long? _____**

- **Allergies: _____**
- **Medications:** (The doctors request that you please write or provide a list of all current medications, including "as needed" meds, at **every** visit.) **Do not write "same"**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- **Preferred Pharmacy Name/Phone #:_____**
- **Other physicians you see:_____**

- **Do you have a living will? Yes or No. If not, do you want one? Yes or No**

PATIENT SIGNATURE:_____