PLAZA FAMILY CARE, P.C.
INTERNAL MEDICINE

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: ________________________________ AGE: ______ GENDER: ____F____M

PLEASE LIST ANY CHRONIC ILLNESS OR MEDICAL PROBLEM WHICH YOU MAY HAVE:

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____

LIST THE MEDICATIONS WHICH YOU CURRENTLY TAKE: ________________________

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WHO WAS YOUR PREVIOUS DOCTOR: ________________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES:			WHAT TYPE / EXPLANATION
1. HIGH BLOOD PRESSURE	YES ____	NO ____	________________
2. DIABETES	YES ____	NO ____	________________
3. ASTHMA	YES ____	NO ____	________________
4. THYROID DISEASE	YES ____	NO ____	________________
5. HIGH CHOLESTEROL	YES ____	NO ____	________________
6. HEART DISEASE / ATTACK	YES ____	NO ____	________________
7. ARTHRITIS	YES ____	NO ____	________________
8. ANEMIA	YES ____	NO ____	________________
9. CANCER	YES ____	NO ____	________________
10. BLEEDING DISORDER	YES ____	NO ____	________________
11. HEPATITIS	YES ____	NO ____	________________
12. KIDNEY DISEASE	YES ____	NO ____	________________
13. STROKE	YES ____	NO ____	________________
14. DEPRESSION	YES ____	NO ____	________________
15. LYME DISEASE	YES ____	NO ____	________________
16. PSYCHIATRIC ILLNESS	YES ____	NO ____	________________
17. SEIZURES	YES ____	NO ____	________________
18. ALCOHOLISM	YES ____	NO ____	________________
19. LUNG DISEASE	YES ____	NO ____	________________
20. IRRITABLE BOWEL	YES ____	NO ____	________________
DO YOU SMOKE	YES ____	NO ____	________________

WHO REFERRED YOU TO OUR OFFICE: ________________________________