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Texas Health Care, PLLC

MEDICAL QUESTIONNAIRE

TODAY'S DATE: _____
NAME: _____ *BIRTHDATE:* _____

REFERRING PHYSICIAN: _____
PRIMARY CARE PHYSICIAN: _____

REASON FOR TODAY'S VISIT:
_____
_____

DIALYSIS PATIENTS:
1. DIALYSIS SCHEDULE _____
2. DIALYSIS FACILITY/ PHONE _____

DRUG ALLERGIES/REACTION:
_____
_____

ARE YOU ALLERGIC TO: *LATEX:* YES / NO *CONTRAST/DYES:* YES / NO

DIABETIC: YES / NO

MEDICAL HISTORY: (Past & current medical illnesses)

Illness:	Year:	Hospital/Physician:
1.		
2.		
3.		
4.		

SURGICAL HISTORY:

Procedure:	Year:	Hospital/Physician:
1.		
2.		
3.		
4.		

MEDICATIONS:

NAME	DOSAGE	NAME	DOSAGE

SOCIAL HISTORY:
Presently smoking: YES NO __ per day
Smoked in past: YES NO If YES, when did you quit: _____
Drink alcohol: YES NO

Marital status: Single ____ Married ____ Divorced ____ Widowed ____

What is your occupation: _____