Luis G. Ramirez, M.D.

Patient Questionnaire

Date: _____ Patient Name: _____ D.O.B. _____

Please provide a brief history of your condition: _____

_____

When did symptoms first appear? _____

_____

Is the above condition related to an accident? ❒ Yes ❒ No
If yes, please describe in detail, how, when and where, the accident occurred: _____

_____

PAST MEDICAL HISTORY

Y	N	Anemia / Radiation Treatment	Y	N	Heart Surgery/ Pacemaker Date: _____
Y	N	Arthritis	Y	N	Hemophilia/ Abnormal Bleeding
Y	N	Artificial Joints	Y	N	Hepatitis
Y	N	Artificial Valves	Y	N	High Blood Pressure (Hypertension)
Y	N	Asthma/ Difficulty Breathing	Y	N	HIV/ AIDS Date: _____
Y	N	Blood Transfusion	Y	N	Kidney Problems
Y	N	Cancer/ Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Congenial U cart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Rheumatic/ Scarlet Fever
Y	N	Emphysema	Y	N	Severe or Frequent Headaches/ Migraines
Y	N	Epilepsy/ Seizures/ Fainting Spells	Y	N	Ulcers/ Colitis
Y	N	Heart Attack Date: _____	Y	N	Venereal Disease
Y	N	Stroke Date: _____	Y	N	Other Serious Medical Conditions

HABITS- Patients 14 Years of age & older, Please complete.

Y	N	Smoke	Started: _____	Stopped: _____	Packs per day: _____
Y	N	Alcohol	Started: _____	Stopped: _____	Avg. Amount: _____
Y	N	Drug Abuse	Started: _____	Stopped: _____	Type of Drug: _____

ALLERGIES-
Aspirin: Y/ N Penicillin: Y/ N Codeine: Y/ N Latex: Y/ N
Other Medications: _____

_____

SURGERY/ HOSPITALIZATION
Y N Surgery- List all & give dates: _____

_____

Y N Hospitalization Not Surgical Related, give dates & reason: _____

_____

MEDICATIONS- Please list all medications you are presently taking.

_____

Patient's Signature: _____