

LAURENCE WEIDER, M.D.
221 W. COLORADO BLVD.
PAVILION II, SUITE 929
DALLAS, TX 75208
214-948-6800

PATIENT HISTORY QUESTIONNAIRE

PATIENT NAME _____ AGE _____ DOB _____

Any known medication allergies? Y N If yes, list medication and allergic reaction:

MEDICAL HISTORY: Please check the appropriate answer if you have or have had:

YES	NO		YES	NO	
___	___	Prolonged bleeding when cut	___	___	Shortness of breath/lung problems
___	___	Diabetes	___	___	Fainting or black out spells
___	___	Stomach/Intestinal disorder	___	___	Visual problems
___	___	High blood pressure	___	___	Joint pains
___	___	Heart trouble/disease	___	___	Excessive scarring
___	___	Heart murmur	___	___	Autoimmune disorder
___	___	Irregular pulse	___	___	Hepatitis
___	___	Cancer _____	___	___	Any other significant illness

If other please describe: _____

FAMILY HISTORY: Please indicate P for father's side of the family or M for mother's side:

YES	NO		YES	NO	
___	___	Diabetes	___	___	High blood pressure
___	___	Heart disease	___	___	Liver disease
___	___	Stomach/Intestinal disorders	___	___	Lung disorder
___	___	Bleeding disorders	___	___	Emotional problems
___	___	Bone or joint problems	___	___	Cancer _____

PERSONAL HISTORY:

Do you smoke? Y N If yes, how many cigarettes/packs per day? _____

Do you drink alcohol? Y N If yes, how much and how often: _____

LIST PREVIOUS HOSPITALIZATIONS OR SURGERIES AND DATE:

MEDICATIONS TAKEN REGULARLY (Including aspirin, birth control pills, herbal medications and/or dietary supplements)

Medication Name _____ Dosage/frequency _____

Medication Name _____ Dosage/frequency _____

Medication Name _____ Dosage/frequency _____

Medication Name _____ Dosage/frequency _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? Y N

IF FEMALE: DATE OF YOUR LAST MENSTRUAL PERIOD? _____

HAVE YOU TAKEN ASPIRIN-CONTAINING DRUGS IN THE PAST TWO WEEKS? _____

OFFICE USE ONLY-

HISTORY REVIEWED: DATE _____ **INITIALS** _____ **DATE** _____ **INITIALS** _____

