HOSPITAL SERVICE DISTRICT NO. 1

PLAQUEMINES MEDICAL CENTER

27136 HIGHWAY 23 • PORT SULPHUR, LA 70083

Name: _____ Date of Birth: _____

Medical History Questionnaire

Please answer yes or no for your medical history.* For family history please, answer yes or no, and if you answer yes, please state the relative (mother, father, grandparents, sister, brother).

*If a disease or surgery is not listed, please explain in the space provided below. (Please Print Clearly)

Disease	Self	Family History
Heart Disease		
High Blood Pressure		
High Cholesterol		
Chest Pain		
Vascular Problems		
Diabetes		
Kidney or Urinary Trouble		
Liver Disease/Hepatitis		
Respiratory Disorder/Asthma		
Shortness of Breath		
Stroke		
Seizures		
Migraines		
Dizziness/Fainting Spells		
Thyroid Problems		
Immune Disorders		
Anemia/Blood Disorders		
Bowel Disorders		
Ulcers		
Cancer		
Arthritis		
Neck or Back Injury		
Leg/knee/hip/ankle Injury		
Elbow/shoulder/wrist Injury		
Depression		
Anxiety		

Surgical History: If you have had a surgery listed below, please put the date.

Surgical History	Date Performed
Heart/Stent/Bypass	
Brain Surgery	
Abdominal/Bowel Surgery	
Hernia Repair	
Thyroid removed	
Gallbladder Removed	
Spleen Removed	
Appendix Removed	
Tonsils removed	
Adenoids removed	
Back Surgery	
Neck Surgery	
Ankle Surgery	
Knee Surgery	
Shoulder Surgery	
Hysterectomy	
C-Section	
Tubal Ligation	
Vasectomy	

*Other Medical History or Surgeries (please list)? _____

_____

Drug or Food Allergies? (please list) _____

Tobacco? Yes____ No_____

Cigarettes ____ Cigars _____Snuff _____Chewing Tobacco_____ Dip____

How much in a day?_____ How long months/years? _____

Alcohol: Do you drink? Yes _____ No _____ How many drinks per/day? _____

Recreational Drug Use: Yes ___ No ___ What drug?_____ How often?_____

Patient or Legal Guardian Signature: _____ Date: _____

Reviewed by Physician: _____

Revised 06/15 LA/CA