

Luis L. Díaz, M.D.

Patient Name: _____

Patient Date of Birth: _____

PATIENT HISTORY QUESTIONNAIRE

Do you **NOW** or **HAVE HAD** any of the following:

- | | |
|--|---|
| ☐ Chest Pain | ☐ Headaches |
| ☐ Shortness of Breath | ☐ Migraines |
| ☐ Asthma | ☐ Fainting/Syncope |
| ☐ High Blood Pressure/HTN | ☐ Seizures |
| ☐ Rapid Heart Beat | ☐ Concussion/Head Injury |
| ☐ Diabetes | ☐ Double Vision |
| ☐ Arthritis | ☐ Dizziness |
| ☐ Rheumatic Fever | ☐ Numbness/Tingling |
| ☐ Heart Disease | ☐ Memory Lapse/Memory Loss |
| ☐ Hyperactivity | ☐ Depression |
| ☐ Insomnia | ☐ Anxiety |

Have you or any of your family/friends had or have been exposed to **COVID-19**?

_____ YES _____ NO Date of Exposure _____

Please mark if you presently have any of the following symptoms:

- | | | |
|--|--|-----------------------------------|
| ☐ Cold | ☐ Stuffy/Runny Nose | ☐ Fever |
| ☐ Flu | ☐ Nausea/Vomiting | ☐ Diarrhea |
| ☐ Coughing | ☐ Sneezing | |
| ☐ No, I don't have any of these symptoms. | | |

Did you get the **COVID-19** Vaccine? YES _____ NO _____

Pfizer _____ Moderna _____ Johnson & Johnson _____

1st Shot Date _____ 2nd Shot Date _____ Booster Date _____

Signature: _____ Date: _____