

JEFFREY A. RICH, D.O
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Male/Female: _____
 Date: _____ Occupation: _____ HT: _____ WT: _____
 SS#: _____ Date of Birth: _____ Referred By: _____

Current problem is the result of a (N): CHECK all that apply.

Car Accident Work Accident Accident Other

Medication	Dose	Reason for Medication	Side Effects

Have any tests been done? X-rays _____ CT Scan _____ MRI _____ OTHER _____
 What treatment have you had for this problem? _____

LIST ALL ALLERGIES: _____
 LIST ANY FAMILY HISTORY OF DISEASE: _____

REVIEW OF SYSTEMS (HAVE YOU HAD, OR DO YOU PRESENTLY SUFFER FROM):

	YES	NO		YES	NO
1. Seizures/Stroke	{ }	{ }	14. Depression or anxiety	{ }	{ }
2. Angina, or Heart Problem	{ }	{ }	15. Psychiatric problems	{ }	{ }
3. High blood pressure	{ }	{ }	16. Chemical Dependency/alcohol	{ }	{ }
4. Asthma or sleep apnea	{ }	{ }	17. Blood clots/phlebitis	{ }	{ }
5. Bronchitis	{ }	{ }	18. Bleeding problems	{ }	{ }
6. Hearing loss	{ }	{ }	19. Difficulty voiding	{ }	{ }
7. Visual loss or glaucoma	{ }	{ }	20. Kidney/bladder infections	{ }	{ }
8. Night sweats, weight gain/loss	{ }	{ }	21. Reaction to general/local anest.	{ }	{ }
9. Cancer	{ }	{ }	22. Psoriasis or other skin problems	{ }	{ }
10. Diabetes	{ }	{ }	23. Have you had steroids	{ }	{ }
11. Hepatitis, jaundice or HIV	{ }	{ }	24. Do you smoke, how much? _____	{ }	{ }
12. Ulcer/GERD/indigestion	{ }	{ }	Patient informed of Smoking Risks	{ }	{ }
13. Thyroid problems	{ }	{ }			

Surgeries/Hospitalizations	Year	Complications

Patient Signature: _____ Physician Signature: _____