

**Medical History Questionnaire**

**Richard G. Buch, M.D.**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Primary Care Provider \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Why are you here today? \_\_\_\_\_

**Patient's Past Medical History (Circle all your previous and/or current medical problems)**

Arthritis    AIDS/HIV    Anxiety    Diabetes    Blood Clots    Cancer    Depression    Heart Disease    Hepatitis

High Blood Pressure    Liver    Lung    Polio    Stroke    Seizures/Epilepsy    Kidney    Stomach Ulcers    Thyroid Problems

**Patient's Past Surgical History (List all surgeries including dental, cosmetic, and elective procedures)**

Name of Surgery	Year	Name of Surgery	Year

Have you ever had general anesthesia?     No     Yes                      Have you every had conscious sedation?     No     Yes  
 Have you ever had any problems with any anesthesia or conscious sedation     No     Yes, describe \_\_\_\_\_

**Family History:** check mark if anyone in your immediate family had or has any of the following disease? If deceased, what age and disease

	Cancer	Diabetes	Heart Disease	High Blood Pressure	Stroke	Deceased, what age and disease
Mother						
Father						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						
Sibling						
Sibling						

**Social History (please check all that apply)**

**Marital Status:**     Single     Married     Other                      **Stressors:**     Home     Work     Relationship  
**Employment:**     Unemployed     Disabled     Retired    Domestic Engineer/Homemaker     Student     Employed  
**Substance Abuse/Recreation Drugs:**     Denies     Yes, what type: \_\_\_\_\_ last used \_\_\_\_\_  
**Alcohol Consumption:**     Denies     Yes: Daily     1-2 drinks/week     1-2 drinks/month     1-2 drinks/year  
**Smoking/Tobacco:**     Denies     Yes \_\_\_ packs/day for \_\_\_ years     Quit: When \_\_\_\_\_     chew     dip  
**Immunizations:**     TD less than 10 years     Pneumococcal less than 5 years     Childhood Immunization Up to Date

**MEDICATION ALLERGIES:**

Medication Name	Reaction	Medication Name	Reaction

**CURRENT MEDICATIONS:** List all prescription, over the counter, herbal, and vitamins you take

Name and Dosage	Name and Dosage	Name and Dosage

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
 Name of Person Completing Form: \_\_\_\_\_ Relation to Patient \_\_\_\_\_

**Health Questionnaire for Richard G. Buch, M.D.**

Circle the items that you have and/or have had in the past

**Childhood Diseases**

Measles	yes	no	Mumps	yes	no	Rubella	yes	no
Diphtheria	yes	no	Tetanus	yes	no	Polio	yes	no
Small Pox	yes	no	Rheumatic Fever	yes	no	Whooping Cough	yes	no
Scarlet Fever	yes	no	Chicken Pox	yes	no	Meningitis	yes	no

**Neurological**

Blackouts	yes	no	Seizures	yes	no	Migraine Headaches	yes	no
Concussions	yes	no	Hit in the Head	yes	no	Lymes Disease	yes	no
Brain Surgery	yes	no	Unconscious	yes	no	Epilepsy	yes	no
Dizziness	yes	no	Stroke/CVA/TIA	yes	no	Difficulty Walking	yes	no
Blurred Vision	yes	no	Double Vision	yes	no	Loss of Bowel/bladder	yes	no

**Cardiovascular**

Angina	yes	no	Palpitations	yes	no	Arrhythmia	yes	no
Lightheaded	yes	no	Fainting	yes	no	Bypass Surgery	yes	no
High BP	yes	no	Low BP	yes	no	Anemia	yes	no
Heart Disease	yes	no	Pacemaker	yes	no	AICD	yes	no
Mononucleosis	yes	no	Bleeding Tendency	yes	no	Heart Murmur	yes	no

**Respiratory**

Hayfever	yes	no	Bronchitis	yes	no	Lung Surgery	yes	no
Allergies	yes	no	Emphysema	yes	no	Pulmonary Edema	yes	no
Asthma	yes	no	Wheezing	yes	no	Pneumonia	yes	no
Short of Breath	yes	no	Pulmonary Embolism	yes	no			
Tuberculosis	yes	no	if yes, date of last ppd _____			or last chest xray _____		

**Gastro-Intestinal**

Reflux	yes	no	Nausea	yes	no	Persistent Vomiting	yes	no
Hiatal Hernia	yes	no	Chronic Diarrhea	yes	no	Lactose Intolerance	yes	no
Peptic Ulcer	yes	no	Chronic Constipation	yes	no	Vomiting Blood	yes	no

**Genito-Urinary**

Incontinence	yes	no	Discharge	yes	no	Painful Urination	yes	no
<input type="checkbox"/> Frequency	yes	no	Bladder Infections	yes	no	Veneral Disease	yes	no
Kidney Disease	yes	no	Bloody Urine	yes	no	Kidney Stones	yes	no

**Other Illnesses**

<input type="checkbox"/> Thyroid	yes	no	Difficulty Hearing	yes	no	Glaucoma	yes	no
<input type="checkbox"/> Thyroid	yes	no	Cataracts	yes	no	Poor Blood Circulation	yes	no
Osteoarthritis	yes	no	Rheumatoid Arthritis	yes	no	Atherosclerosis	yes	no
Cancer	yes	no	Organ Transplant	yes	no	Hemorrhoids	yes	no
Sinus Trouble	yes	no	Hernia R or L	yes	no	Back Trouble	yes	no
Hives	yes	no	Blood Transfusion	yes	no	if yes, when _____		
Eczema	yes	no	Unexplained weight loss	yes	no	Unexplained weight gain	yes	no
AIDS/HIV	yes	no	Hepatitis A B C D E	yes	no	Unexplained rashes	yes	no
Diabetes	yes	no	Other _____					

Type of Birth Control Used \_\_\_\_\_ Are you claustrophobic yes no

Explain all yes answers except childhood illness  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

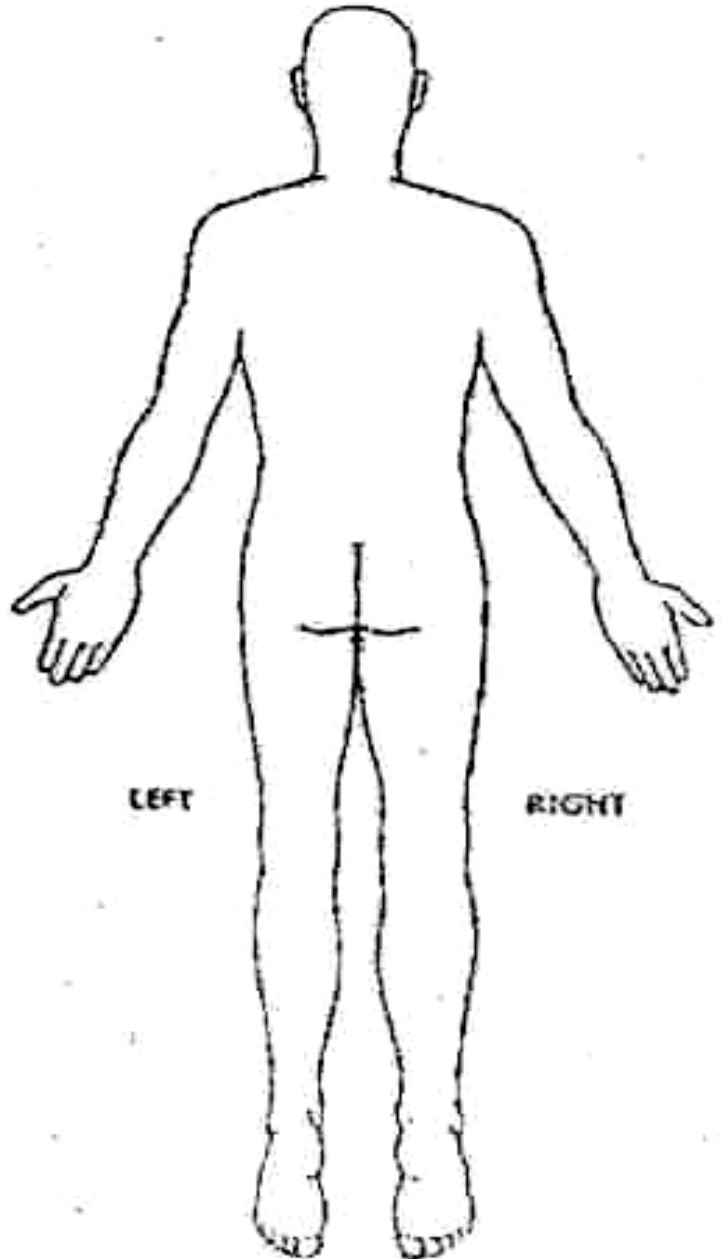
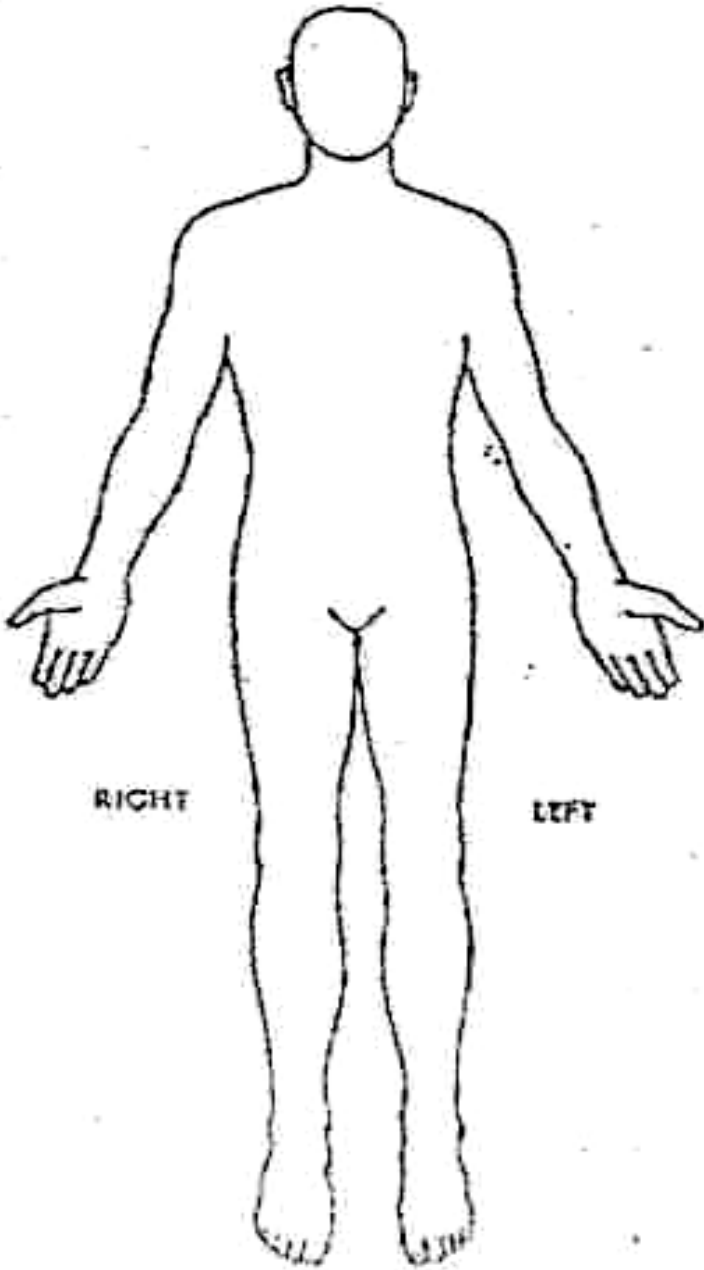
# WHERE IS YOUR PAIN?

Please mark the body image below where you feel the following sensations. Please use the symbols provided

~~~~~ Aches      \*\*\*\* Numbness      xxxx Stabbing      ///// Burning      oooo Pins and Needles  
~~~~~  
\*\*\*\*  
xxxx  
/////

FRONT

BACK



FRONT

BACK

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

