



JOHN S. ROGERSON, M.D., S.C.
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Medical History Questionnaire

Today's Date ____ / ____ / ____

Name _____

Address _____

City _____

State _____ Zip _____

Phone (____) _____ - _____

Insurance _____

Birthdate ____ / ____ / ____ Age _____ Weight _____ Height _____

Chief Complaint: _____

Duration of symptoms: _____

Severity (scale 1-10 with 10 being most severe) _____

Timing (when does pain occur?) _____ Associated symptoms: _____

Modifying factors (what makes symptom better or worse) _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

- | | | | |
|---------------------------------|-----|------------------------|-----|
| Respiratory/Breathing Problems | Y/N | Nerve Disorders | Y/N |
| Asthma | Y/N | Mental health problems | Y/N |
| Lung Disease | Y/N | Depression | Y/N |
| Heart Disease | Y/N | Diabetes: Type I/ II | Y/N |
| Chest Pain | Y/N | Seizures | Y/N |
| High Blood Pressure | Y/N | Stroke | Y/N |
| Heart Murmur | Y/N | Cancer-type _____ | Y/N |
| Blood Disorder/Bleeding Problem | Y/N | Hepatitis | Y/N |
| Severe Anemia | Y/N | Liver Disease | Y/N |
| Blood Clot | Y/N | Skin Disease/Cancer | Y/N |
| Urinary Disorders/Infection | Y/N | Arthritis | Y/N |
| Kidney Disease | Y/N | Rheumatoid | Y/N |
| Stomach Disorder | Y/N | Eye Disease | Y/N |
| Ulcer -Date ____ / ____ / ____ | Y/N | Lupus | Y/N |
| Genital Problem/Disease | Y/N | Amyloidosis | Y/N |

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN (Date and Treating MD)

_____ / ____ / ____

_____ / ____ / ____

_____ / ____ / ____

_____ / ____ / ____



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HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA? (Explain)

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES

(Include date and location)

_____ / / _____
_____ / / _____
_____ / / _____
_____ / / _____
_____ / / _____

MEDICATIONS (Include non-prescription and herbals)

ALLERGIES TO MEDICATION/FOOD/ENVIRONMENT (Explain)

ALLERGY TO METAL: Y/ N

SOCIAL HISTORY

Marital status: Single Married Separated Divorced Widow

Alcohol use: Never Rarely Moderate Daily _____

Tobacco use: Never Rarely Moderate Daily _____

Illicit Drug use: Never Rarely Moderate Daily _____

FAMILY HISTORY

	Age	Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____