Medical History Questionnaire

Date: ____________________

Name: ____________________

Date of Birth: ____________________

Referring Physician: ____________________

Referring Physician's Address (if known): ____________________

Primary Care Physician ____________________ **Medication Allergies:** __________

Past Medical History (Please list all previous and current illnesses, surgeries & injuries)

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Present Medicines and Doses:

____

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Review of Systems (do you presently experience any of the following?)

(Please mark "yes" or "no" to all questions)

Yes	No	Constitutional
☐	☐	Fever/Night sweats
☐	☐	Unexplained Weight Loss
☐	☐	Poor Energy

Yes	No	Eyes
☐	☐	Wear glasses/contacts (circle which one)
☐	☐	Loss of vision
☐	☐	Blurred Vision
☐	☐	Distorted Vision
☐	☐	Loss of Side Vision
☐	☐	Double Vision
☐	☐	Dryness
☐	☐	Eye pain
☐	☐	Mucous Discharge
☐	☐	Redness
☐	☐	Gritty Feeling
☐	☐	Burning/Itching (circle which one)
☐	☐	Excess Tearing
☐	☐	Droopy Eyelids
☐	☐	Foreign Body Sensation
☐	☐	Glare/Light Sensitivity (circle which one)
☐	☐	Flashes or Floaters (circle which one)

Yes	No	Head
☐	☐	Headache

Yes	No	Skin
☐	☐	Rashes
☐	☐	Eczema
☐	☐	Psoriasis

Yes	No	Ears/mouth/nose/throat
☐	☐	Chronic cough
☐	☐	Dry Mouth
☐	☐	Hearing Loss
☐	☐	Ringing in ears
☐	☐	Pain with chewing
☐	☐	Sinus congestion

Yes	No	Respiratory
☐	☐	Asthma
☐	☐	Chronic cough
☐	☐	Chronic bronchitis

Yes	No	Gastrointestinal
☐	☐	Freq. Diarrhea/Constipation
☐	☐	Difficulty swallowing

Medical History Questionnaire

Yes	No	Cardiovascular
☐	☐	Chest Pain
☐	☐	Shortness of breath
		Gentiourinary
☐	☐	Kidney Stones
		Musculoskeltal
☐	☐	Muscle Pain
☐	☐	Joint Pain
		Allergic
☐	☐	Seasonal Allergies
☐	☐	Hay fever
		Endocrine
☐	☐	Excessive thirst
☐	☐	Excessive nighttime urination
		Hematologic/Lymphatic
☐	☐	Blood loss
☐	☐	Anemia

Psychiatric

Please list: ____________________

		Neurologic
☐	☐	Weakness of limbs
☐	☐	Numbness or tingling of body
		Immunizations
☐	☐	Up to date

Family History
(please state who has what condition)

Yes	No	Eyes	
☐	☐	Blindness	____________________
☐	☐	Cataract	____________________
☐	☐	Glaucoma	____________________
☐	☐	Macular Degeneration	__________
☐	☐	Retinal Detachment	___________
☐	☐	Crossed Eyes	______________
☐	☐	Droopy Eyelids	_____________
☐	☐	Similar Condition	____________
		Systemic	
☐	☐	Arthritis	____________________
☐	☐	Cancer	____________________
☐	☐	Diabetes	____________________
☐	☐	Gout	________________________
☐	☐	Heart Attacks	_______________
☐	☐	High Blood Pressure	___________
☐	☐	Kidney Disease	______________
☐	☐	Thyroid disease	_______________
☐	☐	Stroke	____________________

Social History

Yes	No	
☐	☐	**Tobacco** (any type)
		# of packs/day____________
		# of years_______________
☐	☐	**Alcohol**
		#of drinks per day_________
		#of years_______________

Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Occupation: ____________________

Patient's Signature: ____ **Date** __________

(or) Legal Guardian's Signature: __________________________ **Date** __________

I have reviewed this form.

Physician's comments: ____

____

Physician's Signature: ________________________________ **Date** ____________