Williamsburg
5215 Monticello Avenue
Williamsburg, VA 23188

Hampton
3000 Coliseum Dr. Ste 201
Hampton, VA 23666

Confidential Medical History Questionnaire

Name: ____________________ Date of Birth ___/___/_____ Date: ___/___/_____

Do any of the conditions listed below apply to you or your immediate family?
Please check the appropriate column(s).

Eyes	You	Family
Decreased distance vision	☐	☐
Decreased near vision	☐	☐
Distorted vision	☐	☐
Loss of side vision	☐	☐
Double vision	☐	☐
Fluctuating vision	☐	☐
Tired eyes	☐	☐
Flashing lights	☐	☐
Glare/light sensitivity	☐	☐
Night blindness	☐	☐
Floaters	☐	☐
Headache	☐	☐
Dryness	☐	☐
Mucous discharge	☐	☐
Redness	☐	☐
Sandy or gritty feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign body sensation	☐	☐
Pain or soreness	☐	☐
Infection of eye or lid	☐	☐
Sties, Chalazion	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Retinal disorder	☐	☐
Macular degeneration	☐	☐
Strabismus	☐	☐
Blindness	☐	☐

Ears, Nose Throat	You	Family
Hearing Loss	☐	☐
Dizziness	☐	☐
Sinus congestion	☐	☐
Runny nose	☐	☐
Dry Mouth/Throat	☐	☐
Hoarseness Hoa	☐	☐
Sjogren's syndrome	☐	☐

Lungs	You	Family
Asthma	☐	☐
Emphysema	☐	☐
Shortness of breath	☐	☐
Tuberculois	☐	☐
Wheezing	☐	☐
Chronic cough	☐	☐
Heart		
Heart attack	☐	☐
Irregular heart beat	☐	☐
Hypertension	☐	☐
Pacemaker	☐	☐
Coronary artery bypass graft	☐	☐
Congestive heart disease	☐	☐
Chest pains	☐	☐
Nervous System		
Blackout	☐	☐
Migraine	☐	☐
Stroke	☐	☐
Palsy	☐	☐
General		
HIV	☐	☐
Fever	☐	☐
Weight Loss	☐	☐
Lupus	☐	☐
Cancer	☐	☐
Type(s)	☐	☐
Arthritis	☐	☐
Type(s)		☐