

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	Lungs	You	Family
Decreased distance vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Decreased near vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart		
Flashing lights	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Night blindness	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Floater	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Coronary artery bypass graft	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System		
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	Blackout	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	General		
Infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Retinal disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Type(s)	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>			
Blindness	<input type="checkbox"/>	<input type="checkbox"/>			
Ears, Nose Throat	You	Family	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Type(s)		<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>			
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>			
Hoarseness Ho	<input type="checkbox"/>	<input type="checkbox"/>			
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>			

Blood/Lymph Systems

Bleeding, nose, skin, internal
 Blood disorder
 Anemia
 Slow clotting time
 Swollen lymph nodes

You **Family**

Stomach/Intestines

Hepatitis
 Gallstones
 Diarrhea
 Heartburn

Urinary

Kidney disorder
 Kidney stones
 Herpes simplex
 Change in urination

Pregnancy

Are you currently pregnant?

Endocrine

High or low glucose
 Diabetes
 Insulin dependent
 Non-insulin dependent
 Thyroid disorder
 Thirst/hunger change

You **Family**

Skin

Eczema/psoriasis
 Rash

Psychiatric

Depression/mood swings

Allergic

Seasonal allergies
 Anaphylactic reactions

Are you presently nursing?

Drug Allergies:

Name of Current Medications:

List of Surgery and Dates(Women, please include C-Sections):

Date of Last Physical Exam:

Name of Medical Doctor:

Please Stop Here

Physician's Signature:

Date:
