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An AVP Company

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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	❒	❒

Ear, Nose, Throat	**You**	**Family**
Hearing loss	❒	❒
Dizziness	❒	❒
Sinus Congestion	❒	❒
Runny nose	❒	❒
Dry mouth/throat	❒	❒
Hoarseness	❒	❒
Sjogren's Syndrome	❒	❒

Lungs	**You**	**Family**
Asthma	❒	❒
Emphysema	❒	❒
Shortness of Breath	❒	❒
Tuberculosis	❒	❒
Wheezing	❒	❒
Chronic cough	❒	❒

Heart	**You**	**Family**
Heart attack	❒	❒
Irregular heart beat	❒	❒
Hypertension	❒	❒
Pacemaker	❒	❒
Coronary artery bypass graft	❒	❒
Congestive heart disease	❒	❒
Chest pains	❒	❒

Nervous System	**You**	**Family**
Blackout	❒	❒
Migraine	❒	❒
Stroke	❒	❒
Palsy	❒	❒
Seizures	❒	❒

General	**You**	**Family**
HIV	❒	❒
Fever	❒	❒
Weight Loss	❒	❒
Lupus	❒	❒
Cancer:	❒	❒
type(s) _____		
_____		
_____		
_____		
Osteoarthritis	❒	❒
Rheumatoid Arthritis	❒	❒

Blood/Lymph Systems	You	Family
Bleeding nose, skin, internal	❒	❒
Blood disorder	❒	❒
Anemia	❒	❒
Slow clotting time	❒	❒
Swollen lymph nodes	❒	❒

Stomach/Intestines	You	Family
Hepatitis	❒	❒
Gallstones	❒	❒
Diarrhea	❒	❒
Heartburn	❒	❒

Urinary	You	Family
Kidney disorder	❒	❒
Kidney stones	❒	❒
Herpes simplex	❒	❒
Change in urination	❒	❒

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

Skin	You	Family
Eczema	❒	❒
Psoriasis	❒	❒
Rash	❒	❒

Psychiatric	You	Family
Depression/mood swings	❒	❒

Allergic	You	Family
Seasonal allergies	❒	❒
Anaphylactic reactions	❒	❒

Pregnancy	Yes	No
Are you currently pregnant?	❒	❒

	Yes	No
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**