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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?	❐	❐
Are you presently nursing?	❐	❐

Drug Allergies: ______________________________

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Name of Current Medications: ______________________________

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____

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

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Date of Last Physical Exam: ______________________________

Name of Medical Doctor: ______________________________

Please stop here

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______________________ ______________

Physician's Signature **Date**