

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)

Present Medicines and Doses:

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

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

Yes	No	<u>Constitutional</u>	Yes	No	<u>Head</u>
<input type="checkbox"/>	<input type="checkbox"/>	Fever/Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Loss			
<input type="checkbox"/>	<input type="checkbox"/>	Poor Energy			<u>Skin</u>
			<input type="checkbox"/>	<input type="checkbox"/>	Rashes
			<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<u>Eyes</u>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses/contacts (circle which one)			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision			<u>Ears/mouth/nose/throat</u>
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision			Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Pain with chewing
<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Redness			<u>Respiratory</u>
<input type="checkbox"/>	<input type="checkbox"/>	Gritty Feeling			Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Burning/Itching (circle which one)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Droopy Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation			<u>Gastrointestinal</u>
<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity (circle which one)			Freq. Diarrhea/Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Flashes or Floaters (circle which one)	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
			<input type="checkbox"/>	<input type="checkbox"/>	

Medical History Questionnaire

Yes	No	<u>Cardiovascular</u>
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath

<input type="checkbox"/>	<input type="checkbox"/>	<u>Gentiourinary</u>
		Kidney Stones

<input type="checkbox"/>	<input type="checkbox"/>	<u>Musculoskeltal</u>
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain

<input type="checkbox"/>	<input type="checkbox"/>	<u>Allergic</u>
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever

<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine</u>
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Excessive nighttime urination

<input type="checkbox"/>	<input type="checkbox"/>	<u>Hematologic/Lymphatic</u>
<input type="checkbox"/>	<input type="checkbox"/>	Blood loss
<input type="checkbox"/>	<input type="checkbox"/>	Anemia

	<u>Psychiatric</u>
Please list:	_____

<input type="checkbox"/>	<input type="checkbox"/>	<u>Neurologic</u>
<input type="checkbox"/>	<input type="checkbox"/>	Weakness of limbs
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling of body

<input type="checkbox"/>	<input type="checkbox"/>	<u>Immunizations</u>
		Up to date

Family History
 (please state who has what condition)

Yes	No	<u>Eyes</u>
<input type="checkbox"/>	<input type="checkbox"/>	Blindness _____
<input type="checkbox"/>	<input type="checkbox"/>	Cataract _____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment _____
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes _____
<input type="checkbox"/>	<input type="checkbox"/>	Droopy Eyelids _____
<input type="checkbox"/>	<input type="checkbox"/>	Similar Condition _____

<input type="checkbox"/>	<input type="checkbox"/>	<u>Systemic</u>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Gout _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attacks _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____

Social History

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Tobacco</u> (any type)
		# of packs/day _____
		# of years _____
<input type="checkbox"/>	<input type="checkbox"/>	<u>Alcohol</u>
		#of drinks per day _____
		#of years _____

<input type="checkbox"/>	<input type="checkbox"/>	<u>Marital Status</u>
<input type="checkbox"/>	<input type="checkbox"/>	Single
<input type="checkbox"/>	<input type="checkbox"/>	Married
<input type="checkbox"/>	<input type="checkbox"/>	Widowed
<input type="checkbox"/>	<input type="checkbox"/>	Divorced

Occupation: _____

Patient's Signature: _____ **Date** _____

(or) Legal Guardian's Signature: _____ **Date** _____

I have reviewed this form.

Physician's comments: _____

Physician's Signature: _____ **Date** _____