MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Please identify if you currently have or have had any problems in the following areas. If "YES", please explain.

YES/NO

CONSTITUTIONAL SYMPTOMS

( ) ( ) Fever _____
( ) ( ) Weight Loss _____
( ) ( ) Other _____

EYES (See Eye History Sheet)

EAR, NOSE, MOUTH, THROAT

( ) ( ) Sinus congestion _____
( ) ( ) Dry throat/mouth _____

CARDIOVASCULAR

( ) ( ) High blood pressure _____
( ) ( ) Angina _____
( ) ( ) Heart attack _____
( ) ( ) Chest pain _____

RESPIRATORY

( ) ( ) Shortness of breath _____
( ) ( ) Cough _____
( ) ( ) Asthma/Emphysema _____
( ) ( ) TB _____
( ) ( ) Oxygen use at home

SOCIAL HISTORY

( ) ( ) Do you smoke? Packs per day _____
( ) ( ) Do you drink alcohol? How much____
( ) ( ) Do you drive? _____

GASTROINTESTINAL

( ) ( ) Ulcer _____
( ) ( ) Colitis _____
( ) ( ) Hepatitis _____

GENITOURINARY

( ) ( ) Kidney disease _____
( ) ( ) Bladder infections _____
( ) ( ) **History of Benign Prostate Hyperplasia (BPH) or use of Flomax/Like Medications**

MUSCULOSKELETAL

( ) ( ) Arthritis _____
( ) ( ) Joint pain _____

YES/NO

NEUROLOGICAL

( ) ( ) Migraine _____
( ) ( ) Headache _____
( ) ( ) Seizures _____
( ) ( ) Nervous disorders _____
( ) ( ) Stroke _____

ENDOCRINE

( ) ( ) Diabetes: Type 1___ 2____ 3_____
____ Controlled ___ Uncontrolled
( ) ( ) Thyroid _____

HEMATOLOGICAL

( ) ( ) Anemia _____
( ) ( ) Leukemia _____
( ) ( ) Blood transfusions _____
( ) ( ) Sickle cell _____

ALLERGIC AND IMMUNOLOGIC

( ) ( ) Seasonal allergies _____
( ) ( ) Skin rashes _____
( ) ( ) HIV _____

FAMILY HISTORY

( ) ( ) Blindness _____
( ) ( ) Cataract _____
( ) ( ) Glaucoma _____
( ) ( ) Macular degeneration _____
( ) ( ) Retinal detachment _____
( ) ( ) Cancer _____
( ) ( ) Diabetes _____
( ) ( ) Stroke _____
( ) ( ) Thyroid disease _____
( ) ( ) Other _____

Are you on a blood thinner, such as Coumadin, Plavix? _____
Are you on aspirin? _____

Reviewed by Doctor: _____ **- OVER -**