Medical History Questionnaire

Name_____ Date_____

Please check whether **you** have any problems with the following and add the name of the condition.

	Yes	No	
Eyes (poor vision, pain, tearing, redness).....	_____	_____	_____
Neurological (numbness, headache, seizures, paralysis, stroke).....	_____	_____	_____
Ears, Nose, Throat (hard of hearing, ear ache, cough).....	_____	_____	_____
Endocrine (diabetes, thyroid disease).....	_____	_____	_____
Cardiovascular (hypertension, heart disease, irregular heart beat).....	_____	_____	_____
Respiratory (congestion, wheezing, shortness of breath, asthma).....	_____	_____	_____
Gastrointestinal (esophageal reflux, IBS, jaundice).....	_____	_____	_____
Genitourinary (painful/ frequent urination, frequent infection).....	_____	_____	_____
Musculoskeletal (arthritis, joint pain).....	_____	_____	_____
Hematologic (bleeding, anemia, blood thinners).....	_____	_____	_____
Integumentary- skin (pimples, warts, growths, rash).....	_____	_____	_____
Psychiatric (anxiety, depression, insomnia).....	_____	_____	_____
Allergic/Immunologic (sneezing, swelling, redness, itching, hives, lupus).....	_____	_____	_____
Autoimmune Disease.....	_____	_____	_____
General (fever, weight loss or gain).....	_____	_____	_____
Cancer.....	_____	_____	_____
AIDS/HIV Infection.....	_____	_____	_____
Hepatitis.....	_____	_____	_____
Do you smoke?.....	_____	_____	How much?_____
Do you drink alcohol?.....	_____	_____	How much?_____
Females- Are you pregnant? Nursing?.....	_____	_____	_____

Any recent hospitalization Explain._____
_____

Please list all medications that you take._____
_____

Please list all allergies; including medications._____

Please check if there is a Family History of any of the following:

Glaucoma	Cancer	Stroke
Retinal Disease	Hypertension	Diabetes
Blindness	Arthritis	Thyroid Disease
Cataract	Heart Disease	Other heritable disease:

Are you interested in learning more about refractive surgery (LASIK/ PRK) ? Yes No

Physician's Signature _____