Name Date of Birth Date of Service

MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY

Note any family member with the following conditions:
F-father, M-mother, S-sibling, GP-grandparent

	Yes		No		Yes		No
Cancer	☐	____	☐	Macular Degen.	☐	____	☐
Diabetes	☐	____	☐	Glaucoma	☐	____	☐
Thyroid Problems	☐	____	☐	Cataracts	☐	____	☐
Arthritis	☐	____	☐	Blindness	☐	____	☐
Hypertension	☐	____	☐	Crossed Eyes	☐	____	☐
Heart Disease	☐	____	☐	Retinal Disease	☐	____	☐

SOCIAL HISTORY

Health Habits
Check which you use & how much:

	Yes	No
Alcohol	☐	☐
Quantity: _____		
Drugs	☐	☐
Quantity: _____		
Tobacco	☐	☐
Quantity: _____		

Social History
Indicate your hobbies & Interests:

	Yes	No
Computers	☐	☐
Hunting	☐	☐
Golfing	☐	☐
Reading	☐	☐
Fishing	☐	☐
Music	☐	☐

Family Doctor _____ Phone # _____

REVIEW OF SYSTEMS

***** Check the symptoms and/or conditions you currently have or have had in the past. *****

	YES	NO	UNKNOWN
EYES			
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye/Eyelid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Other _____			
CONSTITUTION			
Developmental Disabilities	☐	☐	☐
Cancer	☐	☐	☐
Fatigue Syndrome	☐	☐	☐
Other _____			
EAR, NOSE, THROAT			
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Dry Mouth	☐	☐	☐
Laryngitis	☐	☐	☐
Other _____			
NEUROLOGICAL			
Multiple Sclerosis	☐	☐	☐
Epilepsy	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Tumor	☐	☐	☐
Stroke/CVA	☐	☐	☐
Migraine	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐
Other _____			
PSYCH			
Depression	☐	☐	☐
Attention Deficit	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Bipolar Disorder	☐	☐	☐
Other _____			
CARDIOVASCULAR			
Hypertension	☐	☐	☐
Stroke/CVA	☐	☐	☐
Heart Disease	☐	☐	☐
Vascular Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Other _____			

	YES	NO	UNKNOWN
RESPIRATORY			
Cigarette Smoker	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Obstruction	☐	☐	☐
Sleep Apnea	☐	☐	☐
Other _____			
GASTROINTESTINAL	☐	☐	☐
Crohn's	☐	☐	☐
Colitis	☐	☐	☐
Ulcer	☐	☐	☐
Acid Reflux	☐	☐	☐
Celiac Disease	☐	☐	☐
Other _____			
GENITOURINARY			
Kidney Disease	☐	☐	☐
Prostate Disease/Cancer	☐	☐	☐
STD: Herpes/Chylamidia/Etc.	☐	☐	☐
Pregnant/Nursing	☐	☐	☐
Other _____			
MUSCULOSKELETAL			
Arthritis	☐	☐	☐
Fibromyalgia	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐
Osteoporosis	☐	☐	☐
Gout	☐	☐	☐
Other _____			
INTEGUMENTARY (SKIN)			
Eczema	☐	☐	☐
Rosacea	☐	☐	☐
Psoriasis	☐	☐	☐
Cold Sores/Shingles	☐	☐	☐
Other _____			
ENDOCRINE			
Type 2 Diabetes	☐	☐	☐
Type 1 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Other _____			
BLOOD/LYMPHATIC			
Anemia/Blood Loss	☐	☐	☐
High Cholesterol	☐	☐	☐
Other _____			
IMMUNE			
Rheumatoid Arthritis	☐	☐	☐
Lupus	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐
Other			

ALLERGIES: _____

Name MEDICATIONS: Purpose

_____
