Medical History Questionnaire

Name: _____ Date _____

Use other side if necessary

List any MEDICATIONS you currently take (Rx and Over-The-Counter)	
List any ALLERGIES you have to any medications	
List any major ILLNESSES you have such as glaucoma, diabetes, high blood pressure, heart attack, etc.	
List any OPERATIONS you have had, such as cataract, appendix, cancer surgery, etc.	

Do you currently have any problems in the following areas? If YES, please provide additional information.

			Details
EYES (poor vision, eye pain, tearing, redness, etc.)	YES	NO	
GENERAL CONSTITUTION (fever, weight loss, weight gain, unusual fatigue, etc.)	YES	NO	
EARS, NOSE & THROAT (hard of hearing, stuffy nose, earache, cough, etc.)	YES	NO	
CARDIOVASCULAR (high blood pressure, racing pulse, chest pain, etc.)	YES	NO	
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)	YES	NO	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)	YES	NO	
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)	YES	NO	
FEMALES (Are you pregnant or nursing?)	YES	NO	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthirtis, etc.)	YES	NO	
SKIN (pimples, warts, growths, rash, etc.)	YES	NO	
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)	YES	NO	
PSYCHIATRIC (anxiety, depression, insomnia, etc.)	YES	NO	
ENDOCRINE (diabetes, hypothroid, etc.)	YES	NO	
BLOOD/LYMPH (bleeding, anemia, high cholesterol, problems related to blood transfusions, etc.)	YES	NO	
ALLERGIC/IMMUNOLOGIC (sneezing, itching, hives, Lupus, etc.)	YES	NO	

FAMILY HISTORY

Has any member of your family (parents, grandparents, siblings) had any of these diseases? Circle all that apply.

Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

SOCIAL HISTORY				
What is your occupation?				
Do you drink alcohol?	YES	NO	If yes, how much?	
Do you smoke?	YES	NO	If yes, how much?	