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MEDICAL HISTORY QUESTIONAIRE

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____
(STREET, CITY, STATE, ZIP)

PHONE: _____ SOCIAL SECURITY #: _____

CELL: _____ EMAIL: _____

EMPLOYER: _____ PHONE: _____

Race: _____ Preferred Language: _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

Are you **currently** experiencing any of the following symptoms?

☐ Fatigue ☐ Sore throat ☐ Cough
☐ Chest pressure / discomfort ☐ Abdominal pain
☐ Headache ☐ Back pain

PAST MEDICAL HISTORY / REVIEW OF SYSTEM

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer – type: _____
☐ Chronic Cough
☐ Depression
☐ Hepatitis – type (A, B, C): _____
☐ HIV Positive
☐ High Blood Pressure
☐ Lupus / Sjogrens Syndrome
☐ Pacemaker
☐ Peripheral Vascular Disease
☐ Prostate Disease

(OVER)

Continued – PAST MEDICAL HISTORY / REVIEW OF SYSTEM

☐ Diabetes ☐ Type 1 ☐ Type 2

☐ Excessive Thirst / Urination

☐ Heart Attack

☐ Heart Condition – type: _____

☐ Heart Surgery – type: _____

☐ Rheumatoid Arthritis

☐ Shortness of Breath

☐ Stomach Ulcers

☐ Stroke

☐ Thyroid Disease

FAMILY HISTORY – Has any blood relative ever had the following:

Disease	Yes	No	Relationship to Patient
Cataract	☐	☐	_____
Diabetes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____

List previous eye injuries, eye surgeries, or eye diseases (Macular Degeneration, Cataracts, LASIK, etc.): _____

_____

_____

SOCIAL HISTORY

Do you use tobacco? ☐ Currently ☐ Formerly ☐ Never ☐ Unknown

Type: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Other

Amount per day: _____ Years used: _____

Have you ever tried to quit? ☐ No ☐ Yes Year Quit: _____

Longest tobacco free: _____ Relapse reason: _____

Are you passively exposed to smoke? ☐ No ☐ Yes

Smoker status:

☐ Current every day smoker ☐ Smoker, current status unknown ☐ Former smoker

☐ Current some day smoker ☐ Never smoker ☐ Unknown if ever smoked