MEDICAL HISTORY QUESTIONNAIRE

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

	Yes	No	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/ CONSTITUTIONAL (fever, heat stroke, weight loss weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRETORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (upset stomach, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES: Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

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

Other heritable disease:

Social History

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **Yes** **No**

Have you ever had a blood transfusion?..... **YES** **NO**

Do you drink alcohol?..... **YES** **NO** If **YES**, How Much?_____

Do you smoke?..... **YES** **NO** If **YES**, How Much?_____How many years?_____