

Medical History Questionnaire - Page 1

Patient Name :			Date of Birth: / /	
	ast Firs	t M.I.	,,	
Review of Systems	Do you currently have	e any of these existing condition	ns:	
Blurry vision Vis Discharge Tin Tearing Do Burning Ey Matting San Pain Cha	storted vision sion loss ed eyes uble Vision e dryness ndy or gritty feeling _ ange in eye appearanc	e Peripheral/side vision l	Sinus congestion or lid Stuffy/congested nose g Dry throat/mouth Runny nose oss Pain with chewing	e
Allergy/Immunologi Allergies-seasonal Hay fever symptoms _ Asthma Hives	Abcess	Fatigue (hx) Weakness	Endocrine Diabetes Excess thirst Frequent urination Thyroid Cold Intolerance Heat Intolerance	
Respiratory Cough Shortness of breath Wheezing Dyspnea(hx) Chronic bronchitis	Cardio/Vasc Chest pain _ Murmur Palpitations Valvular dis	Muscle pain Joint pain s Weakness	Gastrointestinal Abdominal pain Constipation Diarrhea	
Hematologic/Lympha Anemia Bleeding Easy bruising Blood clots (hx) Lymphedema (hx) Swollen/Painful lymph	Headache _ Numbness _ Tingling Paralysis Speech imp nodesWeakness _ Ataxia (hx)	Depression (hx) Anxiety airment/difficulty		
Medical /Surgical His	Facial spasr tory	n		
List any major illness/s	surgeries (incl eyelid,	orbit, facial or sinus) (Previou	ıs 5 years only)	
Have you had laser to	eatment or chemica	al peel? YES NO		
Have you ever had a	blood transfusion o	potential exposure to HIV/	'AIDS virus? YES NO	
Do you have an aller	gy to latex? YES NO	If yes, contact or respira	tory?	
Do you have Diabete	s? Do you hav	e a Pacemaker? Do yo	ou have high blood pressure?	
Do you take blood th	inners? □Aspirin	□Persantine □Ecotrin □Co	oumadin □Advil □Naprosyn	
	□Nuprin	□Motrin Other		3/16

Social History Do you drink alcohol? YES NO How often?_____ Do you smoke? YES NO Previous smoked? YES NO Smoking Cessation Info Given:_____ **Family History** Does your family have any history of the following conditions? ****(If yes, only need to indicate one of the following: mother/father/sister/brother/grandparents/uncle/aunt) Droopy eyelids:_____Blindness:_____ Cataracts:_____ Glaucoma:_____ Graves or Thyroid:_____ **Allergies/Medications** Do you have allergies to any medications? YES NO List any_____ Pharmacy Name: _____ City and Crossroad: _____ Pharmacy #:____ List any medication you currently take, including supplements (i.e. Ginseng). NO Medications check here *** May provide a printed copy from PCP or Referring physician *** Medication Dosage Times per day Additional Info **History Reviewed**: ____ NO Changes _____ Additional as noted above (For office use only) Physicians Signature: ______Date: _____

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