Confidential Medical Questionnaire

Name:_____ DOB_____ Date_____

Do you have any problems with the following areas? Please check yes or no

Eyes	Yes	No
Decreased vision at distance	❒	❒
Decreased vision at near	❒	❒
Distorted vision	❒	❒
Flashing lights	❒	❒
Floaters	❒	❒
Glare/light sensitivity	❒	❒
Night blindness	❒	❒
Pain or soreness	❒	❒
Styes or Chalazion	❒	❒
Cataract	❒	❒
Glaucoma	❒	❒
Retinal Disorder	❒	❒
Strabismus (crossed eyes)	❒	❒
Chronic infection of eye or lid	❒	❒
Ear, Nose, Mouth, and Throat		
Hearing loss	❒	❒
Dizziness	❒	❒
Sinus congestion	❒	❒
Dry mouth/throat	❒	❒
Gastrointestinal		
Hepatitis	❒	❒
Gallstones	❒	❒
Diarrhea	❒	❒
Heartburn	❒	❒
Ulcers	❒	❒
Respiratory		
Asthma	❒	❒
Bronchitis	❒	❒
Emphysema	❒	❒
Shortness of breath	❒	❒
Tuberculosis	❒	❒
Wheezing	❒	❒
Chronic cough	❒	❒
Genitourinary		

Cardiovascular	Yes	No
Hypertension	❒	❒
Heart attack	❒	❒
Irregular heart beat	❒	❒
Pacemaker	❒	❒
Bypass graft	❒	❒
Chest pains	❒	❒
Endocrine		
High blood sugar	❒	❒
Low blood sugar	❒	❒
Diabetes	❒	❒
Insulin	❒	❒
Pills	❒	❒
Thyroid disorder	❒	❒
Neurological		
Blackout	❒	❒
Migraine Headache	❒	❒
Stroke	❒	❒
Palsy	❒	❒
Parkinson's Disease	❒	❒
General		
Cancer (where)……..		
(when)……		
Musculoskeletal:		
Arthritis (name type)……		
Hematological/Lymphatic		
Abnormal Bleeding	❒	❒
Blood disorders	❒	❒
Anemia	❒	❒
Sickle Cell anemia	❒	❒
Skin:		
Eczema, psoriasis	❒	❒

Kidney Disorder	❒	❒	Rash	❒	❒
Herpes Simplex	❒	❒	Dry skin	❒	❒
Change in urination	❒	❒	Skin cancer	❒	❒
Psychiatric	Yes	No	Drug Allergies (Penicillin,Sulpha,Antibiotics,		
Depression	❒	❒	……		
Mood swings	❒	❒	…….		
Allergy/Immunology			Date of last medical exam		
Seasonal allergies	❒	❒	……		
Anaphylactic reaction	❒	❒			
HIV	❒	❒			
Do you smoke?	❒	❒	When did you quit?.....		
If yes, how much?.....					
Do you drink alcohol?	❒	❒	When did you quit?.....		
If yes, how much/often……..					

Do you use any drugs or medications **NOT** prescribed by your doctor? If so, what?

……

Medications prescribed by your doctor:

Disease or condition	Medication name	Dosage and Frequency

Surgeries

Part of the body	Disease or condition	Approximate Date

Family History	**Yes**	**No**	**Relation to patient**
Thyroid Disease	❒	❒	……
Diabetes	❒	❒	……
Glaucoma	❒	❒	…….....
Macular Degeneration	❒	❒	……...
High Blood Pressure	❒	❒	……
Systemic Disease	❒	❒	……

Signature……..

Doctor's Signature……Date……