MEDICAL HISTORY QUESTIONNAIRE
REVIEW OF SYSTEMS

Name______________________________ Birth Date______________ Date____________

Do you have any problems in the following areas? If "Yes" please provide information.

EYES	Yes	No			Yes	No	
Loss of vision	___	___	______	Red Eyes	___	___	______
Blurred vision	___	___	______	Itching	___	___	______
Distorted vision (halos)	___	___	______	Burning	___	___	______
Loss of side vision	___	___	______	Dryness	___	___	______
Double vision	___	___	______	Excess tearing	___	___	______
Glare/Light Sensitivity	___	___	______	Lazy eye	___	___	______
Flashes of light	___	___	______	Sties/Chalazion	___	___	______
Floaters	___	___	______	Eye Injury	___	___	______
Eye Surgery	___	___	______	Other______			

		Yes	No	
CONSTITUTIONAL	Fever	___	___	______
	Weight loss	___	___	______
EARS, NOSE, MOUTH, THROAT	Sinus Congestion	___	___	______
	Chronic cough	___	___	______
	Dry throat/mouth	___	___	______
	Runny nose	___	___	______
	Hearing problems	___	___	______
CARDIOVASCULAR	High blood pressure	___	___	______
	Heart disease	___	___	______
RESPIRATORY	Chronic Bronchitis	___	___	______
	Asthma	___	___	______
	Emphysema	___	___	______
GASTROINTESTINAL	Stomach/intestines	___	___	______
GENITOURINARY	Kidney/bladder/genitals	___	___	______
ALLERGIES/ IMMUNOLOGIC				
	Head allergy symptoms	___	___	______
	Seasonal allergies	___	___	______
	Hay fever symptoms	___	___	______
DERMATOLOGIC	Skin and/or breast	___	___	______
NEUROLOGICAL	Stroke	___	___	______
PSYCHIATRIC	Mental Illness	___	___	______
	Depression	___	___	______
ENDOCRINE	Diabetes. insulin	___	___	______
	Diabetes, non insulin	___	___	______
	Thyroid	___	___	______
HEMATOLOGICAL/LYMPHATIC				
	High Cholesterol	___	___	______
	Lymph nodes	___	___	______
	Swelling	___	___	______
MUSCULOSKELETAL	Muscle pain	___	___	______
	Joint pain/Arthritis	___	___	______

(Please complete other side)

PHARMACY NAME____

PHONE____

PAST HISTORY

Present a current list of medications or write them on the "Medical Record" form.

List all major illnesses and injuries____

____

List any surgeries you have had____

____

List any allergies to medications____

____

FAMILY HISTORY (other than yourself)

DISEASES	YES	NO	RELATIONSHIP TO PATIENT
Blindness	____	____	____________________
Cataract	____	____	____________________
Glaucoma	____	____	____________________
Macular Degeneration	____	____	____________________
Retinal Detachment	____	____	____________________
Cancer	____	____	____________________
Diabetes	____	____	____________________
Heart Disease	____	____	____________________
High blood pressure	____	____	____________________

Other____

SOCIAL HISTORY

Current occupation ______________________________

Retired __________

Height ________ Weight ________

Do you drive?	Y	N	
Do you have difficulty seeing street signs?	Y	N	
Do you have any problems with night driving?	Y	N	
Do you drink alcohol?	Y	N	Amount per week ____________
Do you use tobacco?	Y	N	Amount per week ____________
Have you ever had a blood transfusion?	Y	N	

VACCINATIONS	YEAR RECEIVED
Pneumonia	____________
Influenza (flu)	____________
COVID-19	____________

Date Reviewed	Physician Signature: I have reviewed and I agree with Medical History Questionnaire and Medication Record	Tobacco Cessation Counseling		Changes Made	
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N
________	____________________	Y	N	Y	N