Eyesight Associates
A Division of Gayton Health Centre
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# MEDICAL HISTORY QUESTIONNAIRE

Full Name: _____ Preferred name: _____

Primary Care Physician: _____

Pharmacy: _____Location (street & city) _____

## Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes
- □ Diabetes

Blood / Lymph nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling
- □ Fallen X2 in the past year
- □ Injured in fall in past year

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema
- □ Cold Sores

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure
- □ Had Pneumonia shot