Eyesight Associates
A Division of Gayton Health Centre

MEDICAL HISTORY QUESTIONNAIRE

Full Name: _____ Preferred Name: _____

Primary Care Physician: _____

Referring Provider, if any: _____

Preferred 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

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

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting spells
- □ Shortness of breath
- □ Irregular heart beat
- □ Difficulty laying 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 STDs

Psychiatric
- □ Anxiety / Depression
- □ Mood swings
- □ Difficulty sleeping

Endocrine
- □ Increased thirst
- □ Increased appetite
- □ Increased urination
- □ Increased sweating
- □ Fingernail changes
- □ Diabetic

Blood / Lymph nodes
- □ Easy bruising
- □ Gums bleed easily
- □ Prolonged bleeding
- □ Heavy aspirin use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Join Pain / Swelling
- □ Fallen x2 in past year
- □ Falling injury 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
- □ Had Covid Vac x2