Marquette Vision Center

Medical History Questionnaire

(please print) Last Name _____ First Name _____

General / Constitutional (weight loss / gain. fever. ect.)	Yes / No	if Yes please explain.
Ears Nose Mouth Throat: any issues?	Yes / No	if Yes please explain.
Cardiovascular: any issues? (heart. blood vessels. diabetes. high blood pressure. ect.)	Yes / No	if Yes please explain.
Respiratory: any issues? (lungs.breathing.asthma.bronchitis. emphysema. ect.)	Yes / No	if Yes please explain.
Gastrointestinal: any issues? (diarrhea. constipation)	Yes / No	if Yes please explain.
Genitourinary: any issues? (genitals. kidneys. bladder)	Yes / No	if Yes please explain.
Musculoskeletal: any issues? (muscle pain. joint pain. arthritis)	Yes / No	if Yes please explain.
Integumentary: any issues? (skin. breast)	Yes / No	if Yes please explain.
Neurological (headaches. migraines. seizures. etc)	Yes / No	if Yes please explain.

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Psychiatric: any issues? Yes / No if Yes please explain.

_____

Endocrine: any issues? Yes / No if Yes please explain.
(hormones. thyroid. other glands)

_____

Lymphatic / Hematological: any issues? Yes / No if Yes please explain.
(anemia. bleeding problems)

_____

Allergic / Immunologic: any issues? Yes / No if Yes please explain.
(allergic reaction. immune system)

_____

Ocular History: any issues? Yes / No if Yes please explain.
(eye surgery. double vision. loss of vision. glaucoma. cataracts or other ailments)

_____

Medical History: any issues? Yes / No if Yes please explain.
(treatments. surgery)

_____

Ocular Medications: any issues? Yes / No if Yes please explain.
(meds you take for your eyes)

_____

Systemic Medications: any issues? Yes / No if Yes please explain.
(other meds you take)

_____

Allergies: any issues? Yes / No if Yes please explain.
(dogs. cats. foods. seasonal. etc.)

_____

Family History: any issues? Yes / No if Yes please explain.
(diabetic. macular degeneration. cancer. high blood pressure. glaucoma. etc.)

_____

_____ _____

Signature Date