

Medical History Questionnaire (ROS)

Name: _____ Date: _____

Do you have any problems in the following areas? (Check Yes or No)

	YES	NO		YES	NO
General:			GI / GU:		
Fever	_____	_____	Vomiting	_____	_____
Fatigue	_____	_____	Bloody bowel movements	_____	_____
Weight loss or gain	_____	_____	Heartburn	_____	_____
Frequent colds	_____	_____	Loss of appetite	_____	_____
EYES:			Difficulty with urination	_____	_____
Blurred vision	_____	_____	Blood in urine	_____	_____
Double vision	_____	_____	Frequent urination	_____	_____
Redness	_____	_____	Pain in urination	_____	_____
Sandy or gritty feeling	_____	_____	MUSCULOSKELETAL:		
Blind spots	_____	_____	Muscle pain	_____	_____
Floater	_____	_____	Joint pain / arthritis	_____	_____
Flashes	_____	_____	INTEGUMENTARY:		
Lazy Eye	_____	_____	Rash, bruise easily	_____	_____
Itching, burning	_____	_____	Breast disease	_____	_____
Excess tearing	_____	_____	NEUROLOGICAL:		
Glare / light sensitive	_____	_____	Fainting, frequent headaches	_____	_____
Eye pain	_____	_____	Seizures	_____	_____
Chronic infection eye / lid	_____	_____	PSYCHIATRIC:		
ENT: Ears, nose & throat			Depression	_____	_____
Sinus infection	_____	_____	Anxiety	_____	_____
Cough	_____	_____	Psychiatric problems	_____	_____
Trouble walking	_____	_____	ENDOCRINE:		
Hoarseness	_____	_____	Excessive thirst	_____	_____
Loss of hearing	_____	_____	Excessive sweating	_____	_____
Nose bleeds	_____	_____	HEMATOLOGIC / LYMPHATIC:		
HEART:			Swollen glands	_____	_____
Chest pain	_____	_____	ALLERGIC / IMMUNOLOGIC:		
Irregular heart beat	_____	_____	Seasonal allergies	_____	_____
Pacemaker	_____	_____	Hay fever	_____	_____
Heart murmur	_____	_____	OTHER:		
Swollen feet / ankles	_____	_____	Pregnant	_____	_____
Leg cramps when walking	_____	_____	Menopausal	_____	_____
LUNGS:			Vaginal bleeding	_____	_____
Wheezing, shortness breath	_____	_____	Breast lumps	_____	_____
Coughing up blood / phlegm	_____	_____			

COMMENTS REGARDING ABOVE ANSWERS (PLEASE PRINT):
