

Medical History Questionnaire (PFSH)

Name: _____ Date: _____

History: For yourself and <i>each</i> member of your family, check all that apply.	<u>PATIENT</u>		<u>FAMILY MEMBERS</u>					
	YOUR HISTORY	DURATION	<i>Father</i>	<i>Mother</i>	<i>Brother / Sister</i>	<i>Child</i>	<i>Child</i>	<i>Child</i>
Diabetes								
High Blood Pressure								
Heart Disease								
Kidney Disease								
AIDS								
Hepatitis								
Cancer or Tumor								
Respiratory (Lungs)								
Blood Diseases								
Stomach - Ulcer								
Arthritis (Joints)								
Stroke								
Neurologic (Brain)								
Cataract								
Retinal Detachment								
Glaucoma								
Macular Degeneration								
Other								

MEDICATIONS: (LIST)

ALLERGIES & REACTIONS: (LIST)

If you have had any SURGERY in the past, please list:

Type of surgery	Year