

## Patient History (Continued)

**Have you ever had, or do you currently have, any of the following: PLEASE CHECK THOSE THAT APPLY**

- |  |  |
|--|--|
| <input type="checkbox"/> Blindness in either eye             | <input type="checkbox"/> Heart murmur                                      |
| <input type="checkbox"/> Blurred vision                      | <input type="checkbox"/> High blood pressure                               |
| <input type="checkbox"/> Double vision                       | <input type="checkbox"/> Chest pain/angina                                 |
| <input type="checkbox"/> Glaucoma                            | <input type="checkbox"/> Heart attack                                      |
| <input type="checkbox"/> Any recent change in vision         | <input type="checkbox"/> Heart disease                                     |
| <input type="checkbox"/> Date of last eye exam: _____        | <input type="checkbox"/> Irregular/fast heart rate                         |
| <input type="checkbox"/> Diminished hearing/hearing loss     | <input type="checkbox"/> Palpitations/fluttering of heart                  |
| <input type="checkbox"/> Recurrent sinus infection           | <input type="checkbox"/> Leg cramps when walking                           |
| <input type="checkbox"/> Bleeding gums                       | <input type="checkbox"/> Recurrent stomach pain                            |
| <input type="checkbox"/> Recurrent sores in mouth            | <input type="checkbox"/> Recurrent heartburn                               |
| <input type="checkbox"/> Recurrent sores in throat           | <input type="checkbox"/> Poor appetite                                     |
| <input type="checkbox"/> Difficulty swallowing               | <input type="checkbox"/> Nausea or vomiting                                |
| <input type="checkbox"/> Persistent hoarseness               | <input type="checkbox"/> Vomited blood                                     |
| <input type="checkbox"/> Ringing in ears                     | <input type="checkbox"/> Abdominal cramping                                |
| <input type="checkbox"/> Migraine headaches                  | <input type="checkbox"/> Blood with bowel movements                        |
| <input type="checkbox"/> Frequent or severe headaches        | <input type="checkbox"/> Rectal pain with bowel movements                  |
| <input type="checkbox"/> Fainting or dizziness               | <input type="checkbox"/> Recent change in size or shape of bowel movements |
| <input type="checkbox"/> Dizziness with change of position   | <input type="checkbox"/> History of unexplained weight loss                |
| <input type="checkbox"/> Seizure disorders or epilepsy       | <input type="checkbox"/> Jaundice  |
| <input type="checkbox"/> Stroke                              | <input type="checkbox"/> Gallbladder disease                               |
| <input type="checkbox"/> Paralysis                           | <input type="checkbox"/> Hepatitis   |
| <input type="checkbox"/> Numbness or tingling in extremities | <input type="checkbox"/> Liver disease                                     |
| <input type="checkbox"/> Difficulty moving any extremity     | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Chronic back pain                   | <input type="checkbox"/> Low blood sugar                                   |
| <input type="checkbox"/> Backaches                           | <input type="checkbox"/> High blood sugar                                  |
| <input type="checkbox"/> Joint pain                          | <input type="checkbox"/> Prolonged bleeding                                |
| <input type="checkbox"/> Swelling of joints                  | <input type="checkbox"/> Blood clotting disorder                           |
| <input type="checkbox"/> Swelling of hands, feet, or ankles  | <input type="checkbox"/> Easy bruisability                                 |
| <input type="checkbox"/> Muscle spasms                       | <input type="checkbox"/> Steroid medication use                            |
| <input type="checkbox"/> Rheumatoid arthritis                | <input type="checkbox"/> Unexplained fever                                 |
| <input type="checkbox"/> Artificial joints                   | <input type="checkbox"/> Night sweats                                      |
| <input type="checkbox"/> Pins/plates in any joint            | <input type="checkbox"/> Thyroid disease                                   |
| <input type="checkbox"/> Shortness of breath                 | <input type="checkbox"/> Rheumatic fever                                   |
| <input type="checkbox"/> Chronic or frequent cough           | <input type="checkbox"/> Open heart surgery                                |
| <input type="checkbox"/> Coughed up blood                    | <b>Other Medical History</b>   |
| <input type="checkbox"/> Difficulty breathing at night       | <input type="checkbox"/> Muscle aches, pains, weakness                     |
| <input type="checkbox"/> Bronchitis                          | <input type="checkbox"/> Chills  |
| <input type="checkbox"/> Pneumonia                           | <input type="checkbox"/> fatigue   |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Radiation treatments                              |
| <input type="checkbox"/> Emphysema                           | <input type="checkbox"/> Chemo therapy                                     |