

**2020 DAVID A. EWING-CHOW, MD, PLLC
Medical Questionnaire**

Name:	Date of Birth:	Date:
<i>Please check the box below next to the medical conditions or symptoms you have:</i>		Last Eye Exam:

Systemic/General: <input type="checkbox"/> Chills <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Feeling Poorly <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss	Pulmonary: <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Asthma <input type="checkbox"/> Congestion	Psychological: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Tremor <input type="checkbox"/> Insomnia <input type="checkbox"/> PTSD	Endocrine: <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Low Testosterone <input type="checkbox"/> Graves Disease <input type="checkbox"/> Menopause
Head/Eye: <input type="checkbox"/> Eye Pain <input type="checkbox"/> Headache <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Eyesight Problems <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Facial Spasms <input type="checkbox"/> Eye Tearing <input type="checkbox"/> Eye Redness <input type="checkbox"/> Low Vision	Nose/Mouth/Throat: <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Mouth Dryness <input type="checkbox"/> Throat Pain <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Swelling Near Eyes <input type="checkbox"/> Swelling Near Nose <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Earache <input type="checkbox"/> Stuffy Nose	Musculoskeletal: <input type="checkbox"/> Joint Pain <input type="checkbox"/> Decrease in Strength <input type="checkbox"/> Back Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle Cramps	Hematologic/Lymph: <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Swollen Glands/Neck <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Transfusion
Cardiovascular: <input type="checkbox"/> Palpitations <input type="checkbox"/> Skipped Beats <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fast Heart Rate <input type="checkbox"/> Slow Heart Rate <input type="checkbox"/> High Blood Pressure	Gastrointestinal: <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Difficult to Swallow <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Ulcers <input type="checkbox"/> Hernia <input type="checkbox"/> Constipation	Neurological: <input type="checkbox"/> Convulsions <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Motor Disturbances <input type="checkbox"/> Sensory Disturbances <input type="checkbox"/> Double Vision <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Headaches	Skin (Integumentary): <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Rashes <input type="checkbox"/> Jaundice <input type="checkbox"/> Dry Skin <input type="checkbox"/> Warts <input type="checkbox"/> Growths <input type="checkbox"/> Pimples
			Genitourinary: <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequent Urination

Please circle the family member next to any disease that applies to them:

Disease/Condition	Family Member	Disease/Condition	Family Member
Arthritis	Mother Father Sister Brother Daughter Son	Hypertension	Mother Father Sister Brother Daughter Son
Blindness	Mother Father Sister Brother Daughter Son	Lazy Eye	Mother Father Sister Brother Daughter Son
Cancer	Mother Father Sister Brother Daughter Son	Macular Degeneration	Mother Father Sister Brother Daughter Son
Cataract	Mother Father Sister Brother Daughter Son	Multiple Sclerosis	Mother Father Sister Brother Daughter Son
Diabetes	Mother Father Sister Brother Daughter Son	Stroke	Mother Father Sister Brother Daughter Son
Glaucoma	Mother Father Sister Brother Daughter Son	Thyroid Disease	Mother Father Sister Brother Daughter Son
Heart Disease	Mother Father Sister Brother Daughter Son		

PATIENT/GUARDIAN SIGNATURE:	Date:
Provider Signature:	Date: