Berks Eye
Physicians & Surgeons, Ltd.

**Medical History Form-**
Supplemental

Patient Name:_____ Date:_____

Please circle if you are currently experiencing any of the following symptoms (Yes or No) to assist with the entry of your current medical status:

Yes No Fever
Yes No Hearing Loss
Yes No Vertigo
Yes No Cough
Yes No Abdominal Pain
Yes No Vomiting
Yes No Chest Pressure
Yes No Increased Thirst
Yes No Dizziness
Yes No Memory Difficulty
Yes No Changes in Mood
Yes No Dry Skin
Yes No Fatigue
Yes No Nasal Congestion
Yes No Asthma

Yes No Shortness of Breath
Yes No Heartburn
Yes No Changes in Weight
Yes No Sinus Trouble
Yes No Wheezing
Yes No Irregular Heartbeat
Yes No Nausea
Yes No Changes to Urine
Yes No Blood In Urine
Yes No Fast Heartbeat
Yes No Intolerance to heat or cold
Yes No Numbness in Extremities
Yes No Headaches
Yes No Stress
Yes No Rashes