

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____

Date of Birth: _____ Date of last eye exam: _____

List any **medications** you currently take (Prescription and over-the-counter): _____

Do you have **allergies** to any medications? **YES NO**

If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) **and injuries** (concussion, etc.)

Do you **currently** have any problems in the following areas? If YES, please provide additional information:

	YES	NO	EXPLAIN
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, Redness, itching, hives, lupus, etc.)			
FEMALES Are you pregnant? Nursing?			

FAMILY HISTORY

Please indicate = Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply): **YES NO UNKNOWN**
Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
 Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
 Have you ever had a blood transfusion? **YES NO**
 Do you drink alcohol? **YES NO** If YES, how much? _____ a day
 Do you smoke? **YES NO** If YES, how much? _____ How many years?

Physician's signature: _____

Date: _____