

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____
List any medications you currently take (Rx 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) or injuries (concussion, etc): _____ _____
List any surgeries you have had (cataract, appendectomy): _____ _____

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

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL, (fever, heat stroke, weight loss/ gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, 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.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) YES NO UNKNOWN
Blindness, Cataract, 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? _____
Do you smoke?.....YES NO If YES, how much? _____ How many years? _____

Physician's Signature _____ Date _____