

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Date of Birth: _____

Date of Last Eye Exam _____

Do you currently wear Glasses? Yes or No (circle one) Contacts? Yes or No (circle one)

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): _____

*If you are diabetic it is important for us to communicate with your Primary Care Physician (PCP) the results of your dilated eye examination. Please list the name address and phone number of your PCP if you would like us to send a report: _____

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

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 _____