MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ Date: _____

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

List any **medications** (including eye drops) you currently take (prescription and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES** **NO** Latex Allergy? **YES** **NO** Iodine Allergy? **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** (including eye surgeries) you have had: _____

_____

Do you ***currently*** have any problems in the following areas? If YES, please circle all that apply and write in any additional.

	YES	NO	Details
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
ENDOCRINE (Diabetes Type I or Type II, hypothyroid, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, 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?			
EYES (poor vision, eye pain, tearing, redness, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

Arthritis, Blindness, Cancer, Cataract, Diabetes, Glaucoma, Heart Disease, Hypertension, Macular Degeneration, Stroke, Thyroid Disease

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, other _____)?

Have you ever had a blood transfusion? Y N If YES, how much? _____

Do you drink alcohol? Y N If YES, how much? _____

Do you smoke? Y N If YES, how much? _____ How many years? _____

Patient signature: _____ Date: _____

Physician's signature: _____ Date: _____

PHARMACY: _____

CROSS STREETS: _____

PHONE NUMBER: _____