

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, lasik, appendectomy): _____

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

	YES	NO	Details
Eye (poor vision, eye pain, tearing, redness, etc.)			
General/Constitutional (fever, heat stroke, weight loss/gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, cold, earache, 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/frequent urination, impotence, 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, 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

Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc?) **YES NO**

Do you drink alcohol? **YES NO** If YES, how much? _____

Do you smoke? **YES NO** If YES, how much? _____ How many years? _____

Name of Primary Care Physician: _____ Phone: _____

Name of Optometrist or Ophthalmologist: _____ Phone: _____

Physician's Signature _____ Date _____