MEDICAL HISTORY QUESTIONNAIRE

Name ______________________________ Date ______________________________

Date of **Birth** ______________________ Height: ______________ Weight:____________

List any **medications** you currently take and for **what reason** (Rx and over-the-counter): ______________________

____

____

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 have **allergies** to any medications? **YES** **NO** If YES, list the medications: ______________________

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Do you have **allergies** to **latex**? **YES** **NO**

What does you **blood pressure** normally measure?______________________________

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, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, 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, 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, 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, Macular Degeneration, 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? **CURRENT** **FORMER** **NEVER** If CURRENT, how much?_________ How many years?___________

Name of Primary Care Physician: ______________________________ Phone: ______________________