MEDICAL HISTORY QUESTIONNAIRE

Name _____ **Date** _____ Occupation_____

Date of **Birth** _____ Date of **last eye exam** _____

Primary Care Physician: _____ Primary Care Clinic: _____

List of 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, reading, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight 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* _____