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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's 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, 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, 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 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 smoke? ❑ Yes ❑ No If YES, how much? _____ How many years? _____

Physician's Signature: _____ Date: _____/_____/_____