

## MEDICAL HISTORY QUESTIONNAIRE

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Date of Last eye exam** \_\_\_\_\_

What **medications** do you currently take (prescription 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** (eye injuries, concussion etc):

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

	YES	NO	Details
<b>EYES</b> (poor vision, eye pain, tearing, redness, etc.)			
<b>GENERAL/CONSTITUTIONAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, earache, cough, dry mouth, etc)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD/LYMPH</b> (bleeding, anemia, high cholesterol, problems related to blood transfusion, etc.)			
<b>ALLERGIC/IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

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

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

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

Other heritable diseases: \_\_\_\_\_

**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 live alone? **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** \_\_\_\_\_