

MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last eye examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

List all Current Medications (*prescription and over the counter*):

- |          |           |
|----------|-----------|
| 1. _____ | 7. _____  |
| 2. _____ | 8. _____  |
| 3. _____ | 9. _____  |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Do you have **allergies** to any medication?  Yes  No **If Yes, please list:**

Medication	Symptoms
1. _____ -	_____
2. _____ -	_____
3. _____ -	_____
4. _____ -	_____

ILLNESS PAST & PRESENT	YES	NO	DURATION	FAMILY HISTORY	YES	NO	RELATIONSHIP
Glaucoma				Glaucoma			
Arthritis				Arthritis			
Cancer				Cancer			
Diabetes				Diabetes			
Heart Disease				Heart Disease			
High Blood Pressure				High Blood Pressure			
Kidney Disease				Kidney Disease			
Stroke				Stroke			
Thyroid Disease				Thyroid Disease			
Asthma				Asthma			
Hay Fever or Sinus				Hay Fever or Sinus			
Emphysema				Emphysema			
Others:				Others:			

List any eye surgeries you have had (*cataract, corneal transplant, etc*): \_\_\_\_\_

List any surgeries you have had (*appendectomy, tonsillectomy, etc*): \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status (check one):  Married  Divorced  Single  Widowed

Do you drive?  Yes  No

Have you ever had a blood transfusion?  Yes  No If yes, what year? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how many drinks per week? \_\_\_\_\_

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

Review of Systems (examples)	Yes	No	Explanation of Problem
<b>General</b> (glaucoma, cataracts, blurred vision)			
<b>Ears, Nose, Throat</b> (fever, weight loss, fatigue)			
<b>Cardiovascular</b> (chest pain, palpitations)			
<b>Respiratory</b> (cough, shortness of breath, wheezing)			
<b>Gastrointestinal</b> (nausea, vomiting, heartburn, loss of appetite)			
<b>Genitourinary</b> (frequent urination, kidney stones) blood in urine)			
<b>Musculoskeletal</b> (joint pain, muscle weakness or pain)			
<b>Skin</b> (rash, acne, skin cancer, warts)			
<b>Neurological</b> (headaches, paralysis, seizures)			
<b>Psychiatric</b> (depression, anxiety, memory loss)			
<b>Endocrine</b> (diabetes, hypothyroid)			
<b>Hematologic</b> (anemia, bleeding or bruising tendencies)			
<b>Allergic/Immunologic</b> (hay fever, lupus)			

Office Use Only:

History reviewed.  No changes  Changes as noted above.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Signature: \_\_\_\_\_