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Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Approximate Date of Last Eye Exam: _____

List any medications you are currently taking (prescription and over-the counter): _____

_____

List all major illnesses or injuries (glaucoma, diabetes, heart attack, etc.): _____

_____

List any surgeries you have had (cataract, appendectomy, etc.): _____

_____

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

	No	Yes
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)	○	○
BLOOD/LYMPH (bleeding, anemia, etc.)	○	○
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)	○	○
COLLAGEN VASCULAR (lupus, rheumatory arthritis, etc.	○	○
EARS/NOSE/THROAT (hard of hearing, stuffy nose, earache, cough, etc.)	○	○
ENDOCRINE (diabetes, hypothyroid, etc.)	○	○
EYES (poor vision, eye pain, redness, tearing, etc.)	○	○
FEMALES (pregnant, nursing, etc.)	○	○
GASTROINTESTINAL (upset stomach, diarrhea, constipation, ulcer, etc.)	○	○
GENERAL/CONSTITUTIONAL (fever, tired, weight loss/gain, etc.)	○	○
GENITAL/KIDNEY/BLADDER (impotence, frequent/painful urination, etc.)	○	○
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)	○	○
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)	○	○
RESPIRATORY (congestion, wheezing, short of breath, etc.)	○	○
PSYCHIATRIC (anxiety, depression, insomnia, etc.)	○	○
SKIN (pimples, warts, rashes, growths, etc.)	○	○

Details for any YES answer(s) above: _____

_____

Family History

Has any member of your family (parent, grandparent, sibling) had any of the following diseases?

Blindness ☐ No ☐ Yes Diabetes ☐ No ☐ Yes Hypertension ☐ No ☐ Yes

Cancer ☐ No ☐ Yes Glaucoma ☐ No ☐ Yes Stroke ☐ No ☐ Yes

Cataract ☐ No ☐ Yes Heart Disease ☐ No ☐ Yes Other: ☐ No ☐ Yes _____

Social History

Have you ever had a blood transfusion? ☐ No ☐ Yes

Does your vision limit any of your daily activities (driving, hobbies, reading, sports, work)? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes If YES, how much? _____

Do you smoke? ☐ No ☐ Yes If YES, how much? _____

Occupation and job duties: _____

_____

Physician Signature: _____ Date: _____