Medical History Questionnaire

Name ____ Date _______________

**** IF NO CHANGES IN MEDICAL HISTORY, PLEASE SIGN HERE:** __________________________________

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: Date of Birth ________________________ Date of last eye exam ______________

____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, or injuries/concussions, etc.)

____

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, UNUSALLY 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, ARTHRITITS, ETC.)			
SKIN: (PIMPLES, WARTS, GROWTHS, RASH, ETC.)			
NEUROLOGICAL: (NUMBNESS, HEADACHES, SEIZURES, PARALYSIS, ETC,)			
PSYCHIATRIC: (ANXIETY, DEPRESSION, INSOMNIA, ETC.)			
ENDOCRINE: (DIABETES, HYPOTHYROID, ETC.)			
BLOOD / LYMPH: (BLEEDING, CHOLESTEROLEMIA, 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 SIGNATURE: ______________________________ **Date:** ____________