MEDICAL HISTORY QUESTIONAIRE

Name: _____ 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 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, 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, unusually tired)			
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, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anaemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

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, Arthris
Other heritage 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? _____

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____