MEDICAL HISTORY QUESTIONNAIRE

Name:____ Date:_____/_____/_____

Date of last eye examination:_____/_____/_____ Email Address:______________________________

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

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.	______________	—	______________

*Primary care doctor:______________________

ILLNESS PAST AND 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.):

____

____

OVER →

SOCIAL

Occupation: ____

Gender: (circle one) male / female

Marital Status: (circle 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 may 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 area? If "Yes", please provide information.

Review of Systems (examples)	Yes	No	Explanation of Problem
EYES (glaucoma, cataracts, blurred vision)			
GENERAL (fever, weight loss, fatigue)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
CARDIOVASCULAR (heart/chest pain, palpitations)			
RESPIRATORY (asthma/emphy., cough, shortness of breath, wheezing)			
GASTROINTESTINAL (nausea, vomiting, heartburn, loss of appetite)			
GENITOURINARY (frequent urination, kidney stones, blood in urine)			
MUSCULOSKELETAL (joint pain, muscle weakness or pain)			
SKIN (rash, acne, skin cancer, warts)			
NEUROLOGICAL (heart attack, stroke, headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
ENDOCRINE (diabetes, hypothyroid)			
HEMATOLOGIC (anemia, bleeding or bruising tendencies)			
ALLERGIC/IMMUNOLOGIC (arthritis, hay fever, lupus)			

Office Use Only:

History reviewed. ☐ No changes ☐ Changes as noted above.

Date: ______/______/______ Doctor's Signature: ______________________________