

Medical History Questionnaire

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 the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heat attack, etc.) or **injuries** (concussion, etc.) :

List any surgeries you have had:

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/gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (upset stomach, 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, migraines, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

Has any blood relative 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?