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, heart attack, etc.) or injuries (concussions, 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.

EYES (poor vision, eye pain, tearing, redness, etc.)	YES	NO
GENERAL CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)	YES	NO
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc)	YES	NO
CARDIOVASCULAR (high BP, racing pulse, etc)	YES	NO
RESPIRATORY (congestions, wheezing, short breath, etc.)	YES	NO
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)	YES	NO
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundicem, etc)	YES	NO
FEMALES (are you pregnant, nursing)	YES	NO
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)	YES	NO
SKIN (pimples, warts, growths, rash, etc.)	YES	NO
NEUROLOGICAL (numbness, headaches, seizures, paralysis, etc.)	YES	NO
PSYCHIATRIC (anxiety, depression, insomnia)	YES	NO
ENDOCRINE (diabetes, hypothryroid, etc.)	YES	NO
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)	YES	NO
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)	YES	NO

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)
Has any member of your family had these diseases? YES NO UNKNOWN

Check all that apply	Blindness	Cataract	Glaucoma	Diabetes	Cancer
	Hypertension	Heart Disease	Stroke	Arthritis	Thyroid Disease

If so, please indicate relationship (Mother/Father)

Other inheritable disease

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.) 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's Signature Date