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Medical History Questionnaire

Patient's Name: _____ Phone Number: _____
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** (concussion, etc.): _____

_____

List any **surgeries** you have had (cataract, appendectomy): _____

_____

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)			
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.)			

	YES	NO	DETAILS
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

	YES	NO	UNKNOWN
Has any member of your family had these diseases (check all that apply) ?			

☐ Blindness ☐ Cataract ☐ Glaucoma ☐ Diabetes ☐ Hypertension
☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Thyroid Disease ☐ Arthritis
Other heritable disease: _____

SOCIAL HISTORY

	YES	NO
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?		
Have you ever had a blood transfusion?		
Do you drink alcohol? **If YES**, how much? _____		
Do you smoke? **If YES**, how much? _____ How many years? _____		

_____ _____
Signature Date

(Physician's Signature)