MEDICAL HISTORY QUESTIONNAIRE

NAME: **DATE:**

Date of **Birth** ____________________ Date of **last eye exam**__________________

List any **medications** you currently take (prescription and over-the-counter): ______________________________

Do you have new allergies to any medications since your last visit? **YES** **NO**
If yes, list the medications: ______________________________

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attach, etc.) or injuries (concussion, etc.): ______________________________

List any surgeries you have had (cataract, tonsillectomy, appendectomy): ______________________________

Do you *currently* have any problems in the following areas?:

If YES, please provide information.	YES	NO	Details
EYES			
Blurred vision			
Glare or light sensitivity			
Dryness			
Redness			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Problems with night driving			
Any other current eye problem?			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			

(...continued) If YES, please provide information.	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Diabetes			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			

SOCIAL HISTORY

Do you drink alcohol?	**YES**	**NO**	If YES:	occasional	1 / day	2-3/day	4+/day
Do you smoke?	**YES**	**NO**	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: ____ *Date:* ______________