

# 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** (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
<b>EYES</b> (poor vision, eye pain, tearing, redness, etc.)			
<b>GENERAL / CONSTITUTIONAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

**FAMILY HISTORY** (Mother, Father, Grandparent, Sibling)

Has any member of your family 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? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_