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Medical History Questionnaire

Patient Name: _____ Date of Exam: _____

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? If yes, please list: _____

Pharmacy Name & Location (phone #, cross-streets and city): _____

_____

List all major illnesses *including those that are well managed with medication* (glaucoma, macular degeneration, cancer, diabetes, high blood pressure, heart attack, stroke, COPD, asthma, arthritis, lupus, memory problems, Parkinson's, etc.) or injuries (concussion, etc.): _____

_____

List any surgeries you have had (tonsillectomy, appendectomy, joint replacement, etc.): _____

_____

List any ocular surgeries or procedures you have had, including the date and performing doctor if available (LASIK, cataract surgery, glaucoma laser, etc.): _____

_____

Social History

Occupation/Former Occupation: _____

Do you drink alcohol? No Yes If Yes, approximately how much? 1-2 drinks/day 3-4 drinks/day Occasional/Social

Do you currently smoke? No Yes If Yes, how much? _____ Have you ever smoked? No Yes

Primary Care Physician Name: _____

Referring Doctor Name and/or Name of Office: _____

Family History

Condition	Mother	Father	Sister	Brother	Grandmother	Grandfather	Unknown
Arthritis							
Blindness							
Cancer							
Cataract							
Diabetes							
Glaucoma							
Heart Disease							
Hypertension							
Stroke							
Thyroid Disease							
Other Heritable Disease:							

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Review of Systems

Are you **CURRENTLY EXPERIENCING** **new or worsening** symptoms in any of the following areas?			
Area	Yes	No	Description
EYES (poor vision, eye pain, tearing, redness, discharge, etc.)			
GENERAL/CONSTITUTIONAL (fever, cold symptoms, difficulty chewing, significant weight loss/gain, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, etc.)			
CARDIOVASCULAR (lightheadedness, racing pulse, chest pain, swelling of the feet, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, coughing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, etc.)			
GENITAL, KIDNEY, BLADDER (painful/frequent urination, impotence, blood in urine, etc.)			
FEMALES (pregnant/nursing)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (rash, change in mole, acne, rosacea, etc.)			
NEUROLOGICAL (headache, numbness, scalp tenderness, dizziness, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (shakiness, sweating, feeling of low blood sugar, excessive thirst, etc.)			
BLOOD/LYMPH (excessive/prolonged bleeding, bruising easily, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, redness, itching, hives, swelling, etc.)			

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