

# 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:							

**Review of Systems**

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