

## MEDICAL HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of <b>Birth</b> _____	Date of <b>Last Eye Exam</b> _____
List any <b>Medications</b> you currently take (Rx and over-the-counter): _____ _____	
Do you have <b>Allergies</b> to any medications? <b>YES</b> <b>NO</b> If YES, list the medications: _____	
<b>LATEX ALLERGY:</b> <b>YES</b> <b>NO</b> <b>Iodine Allergy:</b> <b>YES</b> <b>NO</b>	
List all <b>Major Illnesses</b> (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (Concussion, etc.): _____ _____	
List any <b>Surgeries</b> you have had (cataract, appendectomy, etc.): _____	

Do you **currently** have any problems in the following areas? If YES, 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, ear ache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath)			
<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)?	<b>YES</b>	<b>NO</b>	<b>UNKNOWN</b>
<b>Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis</b>			
Other Heritable Disease: _____			

### SOCIAL HISTORY

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

*Patient's Signature* \_\_\_\_\_

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