Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Date of last eye exam: _____

List any medications you currently take (Rx and over the counter) _____
Do you have any **allergies** to any medications? Yes No If Yes please list _____
List all major illnesses: (glaucoma, diabetes, high blood pressure, heart attack etc.) or injuries (concussions, etc.)
List **ALL** surgeries you have had (cataracts, appendectomy etc): _____

Do you **currently** have any problems in the following areas? If **YES**, please provide additional information.

	YES	NO	Details
Eyes (poor vision, eye pain, tearing, redness etc.)			
General / Constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
Cardiovascular (high blood pressure, racing pulse, etc,)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (upset stomach, diarrhea, constipation, hernia, ulcer, etc.)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
Females: Are you pregnant? Nursing?			
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood / Lymph (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
Allergic / Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History (Mother, Father, Grandparents, Sibling)

Has a member of your family had these diseases (circle one)? Yes No Unknown

Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other inheritable 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: _____