MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Birth Date:_____ Age:_____

Who lives in your household?_____
Name of Doctor referring you:_____ Clinic:_____
Name of Primary Care Physician:_____ Clinic:_____
Pharmacy: _____ Location: _____

MEDICAL HISTORY: Please circle all major illnesses.

Anxiety	COPD	Hypertension	Lymphoma
Arthritis / Rheumatoid	Coronary Artery Disease	HIV/AIDS	Prostate Cancer
Asthma	Depression	High Cholesterol	Radiation Treatment
Atrial Fibrillation	Diabetes	Hyperthyroidism	Seizures
Bone Marrow Transplant	End Stage Renal Disease	Hypothyroidism	Stroke
Breast Cancer	Hearing Loss	Leukemia	Other _____
Colon Cancer	Hepatitis	Lung Cancer	_____

List all major injuries: _____
_____
List all surgical procedures excluding the eye:_____
_____

EYE HISTORY: Please circle Y-YES or N-NO:

Y N Pain	Y N Dryness	Y N Tearing	Y N Irritation
Y N Itching	Y N Blurry Vision	Y N Redness	Y N Floaters
Y N Distortion	Y N Light Flashes	Y N Double Vision	Y N Light Sensitivity
Y N Halos around light	Y N Lazy Eye	Y N Glare	Y N Loss of Vision

Other (please describe):_____

Previous eye diagnosis:_____
Previous eye injuries or surgeries:_____
Do you wear glasses? Y N If yes, how old are they?_____
Do you wear contacts? Y N If yes; How long?_____ **What brand?**_____**Power**: _____

FAMILY HISTORY: Please check all that apply

Please circle any blood related family members who have/had any of the following.

F – Father M – Mother B – Brother S – Sister A – Aunt U – Uncle GF – Grandfather GM - Grandmother

Diabetes	F M B S A U GF GM	Macular Degeneration	F M B S A U GF GM
Glaucoma	F M B S A U GF GM	Thyroid Disease	F M B S A U GF GM
Cataract	F M B S A U GF GM	Retinal Detachment	F M B S A U GF GM
Blindness	F M B S A U GF GM	Amblyopia/Strabismus	F M B S A U GF GM
Arthritis	F M B S A U GF GM	Heart Problems	F M B S A U GF GM
Cancer	F M B S A U GF GM	High Blood Pressure	F M B S A U GF GM

(Type) _____

Other (please describe)_____

Next side ➡

SOCIAL HISTORY

Do you smoke? YES NO If yes, how much? _____How long?_____Never Smoked _____

Are you a former smoker? YES When did you quit? _____

Do you drink alcohol? YES NO If yes, how often? _____

Do you drive? YES NO Please check all that apply: □ Daytime driving □ Night driving

REVIEW OF SYSTEMS

Do you currently have any symptoms/conditions in the following areas, even if controlled by medication?

Please check the box for any condition that applies:

- □ Fever
- □ Unexpected Weight Loss
- □ Stuffy Sinuses
- □ Sore Throat
- □ Cough
- □ Trouble Swallowing
- □ High Blood Pressure
- □ Chest Pain
- □ Congestion
- □ Wheezing
- □ Shortness of breath
- □ Stomach Pain
- □ Diarrhea
- □ Urinary Frequency
- □ Joint Pain
- □ Muscle Pain
- □ Arthritis / Rheumatoid? Y N
- □ Rash
- □ Changing Skin Lesions
- □ Skin Disesase/Disorder
- □ Headache
- □ Stroke
- □ Migraine
- □ Numb/Tingling – Hands or Feet
- □ Anxiety
- □ Depression
- □ Insomnia
- □ Easy Bleeding/Bruising
- □ Anemia
- □ Seasonal Allergies
- □ Hay Fever
- □ Thyroid Abnormalities

- □ **Diabetes – On Insulin? Y N**
  How Long? _____

Recent Fasting Blood Sugar _____

Recent Hemoglobin A1C _____

ALLERGIES

☐ No known drug allergies

Please list any prescription or non-prescription medications that you are allergic to: _____

_____

Please list any allergies other than to medications: _____

_____

MEDICATIONS

Please list all prescription AND non-prescription (over-the-counter) medications that you are currently taking. Include all eye drops prescription AND non-prescription (over-the-counter).

Name of Medication	**Dosage**	**Frequency – How often taken?** (once a day, as needed, etc.)

_____ /_____ _____

Patient or Guardian Signature | Relationship to patient | Date

Thank you!