MEDICAL HISTORY QUESTIONNAIRE

Name:_____Birthdate:_____Age:_____Date:_____

◆Past Eye History

Last eye exam:_____Name and location of Eye Doctor:_____Type of treatment: _____

Do you wear: Glasses? ❑Yes ❑No Last Worn:_____ Contact Lenses? ❑Yes ❑No Last Worn: _____

Have you ever been diagnosed with any of the following eye problems:

DISEASE/CONDITION	SELF YES	SELF NO	EXPLAIN	MEDICATIONS: NONE ❑
Injury	❑	❑	_____	
Surgery	❑	❑	_____	
Disease	❑	❑	_____	
Blindness	❑	❑	_____	
Cataract	❑	❑	_____	
Strabismus	❑	❑	_____	
Lazy Eye (Amblyopia)	❑	❑	_____	
Glaucoma	❑	❑	_____	
Macular Degeneration	❑	❑	_____	
Other _____	❑	❑	_____	

Family Medical History

Has anyone in your blood related family (parents, grandparents, siblings, children; (living or deceased) ever been diagnosed with any of the following conditions:

DISEASE/CONDITION	YES	NO	RELATION	EYE PROBLEMS	YES	NO	RELATION
Arthritis	❑	❑	_____	Blindness	❑	❑	_____
Cancer	❑	❑	_____	Cataract	❑	❑	_____
Diabetes	❑	❑	_____	Strabismus	❑	❑	_____
Heart Disease	❑	❑	_____	Lazy Eye (Amblyopia)	❑	❑	_____
High Blood Pressure	❑	❑	_____	Glaucoma	❑	❑	_____
Nerve Condition	❑	❑	_____	Macular Degeneration	❑	❑	_____
Thyroid Disease	❑	❑	_____	Other	❑	❑	_____

Name and Location of Medical Doctor:_____ Dr.'s Phone:_____

Name and Location of Specialist Doctor:_____Dr.'s Phone:_____

Last Medical Exam:_____ Reason for treatment:_____

Do you have allergies to medications? ❑ Yes ❑ No If yes, explain:

Do you have allergies to non-medication items? ❑ Yes ❑ No If yes, explain:

List all major injuries, surgeries and/or hospitalizations you have had:

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my social History information with my doctor. (check box) ❑

Employer or School:_____Occupation/School_____

What hobbies or avocations do you have?_____

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long:_____

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long:_____

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

◆Review of Systems

No Medications ❑

Medications:

Constitution None_____

❑ developmental disability
❑ fatigue
❑ trauma
❑ weightloss/gain
❑ other

Integumentary None_____

❑ eczema
❑ psoriasis
❑ rosacea
❑ other

Neurological None_____

❑ headache
❑ migraine
❑ multiple sclerosis
❑ seizures
❑ stroke damage
❑ other

Ear, Nose, & Throat None____

❑ dry throat/mouth
❑ hearing loss
❑ sinus drainage
❑ other

Respiratory None_____

❑ asthma
❑ bronchitis
❑ emphysema
❑ lung cancer
❑ other

Gastrointestinal None_____

❑ Crohn's
❑ diarrhea
❑ hiatal hernia
❑ reflux
❑ ulcer
❑ other

Endocrine None_____

❑ Hormonal
❑ Thyroid
❑ Diabetes
First diagnosed:_____
Last check up:_____
Family with:_____
❑ other

Cardiovascular None_____

❑ heart disease
❑ hypertension
❑ stroke
❑ vascular disease
❑ other

Hematological/Lymphatic None_____

❑ anemia
❑ cholesterol
❑ leukemia
❑ triglycerides
❑ other

Psychiatry None_____

❑ Alzheimer's
❑ depression
❑ nerve condition
❑ panic disorder
❑ psychosis
❑ other

Genitourinary None_____

❑ genital
❑ kidney ailments
❑ urinary tract infections
❑ other

Musculoskeletal None_____

❑ ankylosing spondylitis
❑ fibromyalgia
❑ muscular dystrophy
❑ osteoarthritis
❑ other

Allergic/Immunologic None_____

❑ drug allergy
❑ environmental allergy
❑ lupus
❑ rheumatoid arthritis
❑ sarcoid
❑ other

_____ _____

Doctors Signature Date