

MEDICAL HISTORY QUESTIONNAIRE



001

NAME: _____ **D.O.B.** _____ **DATE:** _____

Date of last eye exam: _____ **Referred by:** _____

List any **medications** you currently take (prescription and over-the-counter):

Do you have **allergies** to any medications? YES _____ NO _____
 IF YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, etc.):

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

	YES	NO	EXPLAIN
Do you or have you ever worn contact lenses?			
EYES (Glaucoma, cataract, retinal disease, etc.)			
GENERAL/CONSTITUTIONAL (Fever, weight loss/gain, fatigue etc.)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, circulation, HTN, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Skin cancer, etc.)			
NEUROLOGICAL (Stroke, seizures, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
ENDOCRINE (Diabetes, thyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

SOCIAL HISTORY

DISEASE	YES	NO	DISEASE	YES	NO	
Blindness			Cataracts			Occupation: Current or Retired from : _____ Do you drink alcohol? YES _____ NO _____ Do you smoke? YES _____ NO _____ Marital Status: _____ Have you ever had a blood transfusion? YES _____ NO _____ If YES, when? _____
Glaucoma			Arthritis			
Cancer			Diabetes			
Heart disease or hypertension			Kidney disease			
Lupus			Stroke			
Thyroid disease			Other			

ADVANCE DIRECTIVES (check all that apply)

I have: Living Will Power of Attorney (POA) Type of POA _____
 I am interested in receiving information regarding Advance Directives Yes No

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

Updated: _____