

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____
 Date of Birth ____/____/____ Social Security _____
 Date of Last Eye Exam _____
 Date of Last Medical Exam _____
 Name of Medical Doctor _____

Reason for visit today? _____

Medical History

List any medications you are currently taking (including oral contraceptives and over the counter medications) _____

List any medication allergies: _____

List any major surgeries (Eye or Other) _____

Circle any of the following you have had: Crossed eye, Lazy eye, Drooping eyelid, Glaucoma, Retinal disease, Cataracts, Eye injury, or Eye infections.

Are you pregnant or nursing? NO YES

If you wear glasses how old is current pair _____

If you wear contact lenses how old is current pair _____

Type/Brand of contact lenses and power _____

Hobbies which require special visual demands _____

Family History

Please note any family history (parents, grandparents, siblings) for the following conditions.

DISEASE/CONDITION	NO	YES	Relationship to you
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment/disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History *This information is confidential. However, you may discuss this portion with the doctor if you prefer.* Yes, I prefer to discuss my social history with the doctor.

If you smoke tobacco products, list type/amount/how long _____

If you drink alcohol, list type/amount/how long _____

If you use illegal drugs, list type/amount/how long _____

Review of Systems: Please describe any significant problems in the following areas: Fever, Weight loss/gain, Skin, Migraines, Seizures, Thyroid/Other glands, Diabetes, Allergies, Hay Fever, Asthma, Chronic Bronchitis, Emphysema, High Blood Pressure, Heart Problems, Cancer, Kidney Disease, Rheumatoid Arthritis, Anemia, Bleeding problems, Digestive, Psychiatric, Other.

