MEDICAL HISTORY QUESTIONNAIRE

NAME:_____DATE:_____

DATE OF BIRTH:___/___/____ DATE OF LAST EYE EXAM:_____

ALL MEDICATIONS : ***MAJOR ILLNESSES(ALL INCL. EYE):***

ALLERGIES(MEDICATION & ENVIRONMENTAL):_____

SURGERIES INCLUDING EYE:_____

PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE ADDITIONAL DETAILS

- **EYES (POOR VISION/EYE PAIN/TEARING/REDNESS/ETC) □YES □NO**
- **GENERAL(FEVER/WEIGHT GAIN/LOSS/TIRED) □YES □ NO**
- **EARS/NOSE/THROAT(POOR HEARING/COUGH/DRY MOUTH/ETC) □YES □ NO**
- **CARIDIOVASCULAR(HIGH BP/HIGH PULSE/ETC) □YES □ NO**
- **RESPIRATORY(WHEEZING/SHORT OF BREATH/ETC) □YES □ NO**
- **GASTROINTESTINAL(STOMACH/INTESTINAL/ULCER/HERNIA/ETC) □YES □NO**
- **GENITAL,KIDNEY,BLADDER(IMPOTENCE/JAUNDICE/URINATION ISSUES/ETC) □YES □NO**
- **FEMALES(PREGNANT/NURSING/ETC) □YES □ NO**
- **MUSCLES,BONES,JOINTS(JOINT PAIN/STIFFNESS/ARTHRITIS/ETC) □YES □NO**
- **SKIN(RASH/GROWTH/WARTS/ETC) □YES □NO**
- **NEUROLOGICAL(NUMBNESS/SEIZURES/HEADACHE/ETC) □YES □NO**
- **PSYCHIATRIC(ANXIETY/DEPRESSION/INSOMNIA) □YES □NO**
- **ENDOCRINE(DIABETES,HYPO/HYPER THYROID/ETC) □YES □NO**
- **BLOOD/LYMPH(BLEEDING/ANEMIA/ETC/TRANSFUSIONS) □YES □NO**
- **ALLERGIC/IMMUNOLOGIC(SNEEZING/ITCHING/HIVES/LUPUS/ETC) □YES □NO**
- **CANCER(ANY) □YES □NO**

(PLEASE TURN SHEET OVER)

FAMILY HISTORY:

(MOTHER/FATHER/G-MOTHER/G-FATHER/SIBLINGS)

- **ADOPTED** **□YES** **□NO**
- **BLINDNESS** **□YES,WHOM:_____** **□NO**
- **CATARACT** **□YES,WHOM:_____** **□NO**
- **KERATOCONUS** **□YES,WHOM:_____** **□NO**
- **GLAUCOMA** **□YES ,WHOM:_____** **□NO**
- **DIABETES** **□YES ,WHOM:_____** **□NO**
- **HEART DISEASE** **□YES,WHOM:_____** **□NO**
- **CANCER** **□YES,WHOM_____** **□NO**

SOCIAL HISTORY:

- **DRINK ALOCHOL □YES,HOW MUCH_____** **□NO**
- **SMOKE □YES ,HOW MUCH & LONG _____** **□NO**
- **LIVING ARRANGEMENTS_____**
- **DRIVING HABITS(LIMITATIONS/ETC)_____**
- **MARITAL STATUS_____**
- **EMPLOYMENT(RETIRED/FULLTIME/PT TIME/STUDENT/UNEMPLOYED)**

_____

PHYSICAN
SIGNATURE_____DATE_____