

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)

