

Medical History Questionnaire

NAME _____

Date _____

PAST MEDICAL HISTORY:

List all **Major Illnesses** (Diabetes, High Blood Pressure, heart disease, cancer, etc...) or **Injuries**:

List all **Eye Surgeries** and **Laser** procedures you have had (include date, eye, etc ...):

List all other **Surgeries** you have had:

List all **Medications** you currently take (prescription and over-the counter, vitamins, eye drops):

Do you have any **Allergies** to medications? Yes [] No [] If Yes, list the medications:

| FAMILY HISTORY: | YES | NO | RELATIONSHIP TO PATIENT |
|-----------------------------|------------|-----------|--------------------------------|
| Glaucoma | _____ | _____ | _____ |
| Cataract | _____ | _____ | _____ |
| Macular Degeneration | _____ | _____ | _____ |
| Crossed or Drifting of Eyes | _____ | _____ | _____ |
| Blindness | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ |
| Other | _____ | _____ | _____ |

SOCIAL HISTORY:

Current Occupation OR Student's grade _____

Do you drink alcohol? (adults only) YES [] NO [] If yes, how much? _____

Do you smoke? (adults only) YES [] NO [] If yes, how many packs per day? _____

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Date _____

REVIEW OF SYSTEMS:

| | YES | NO | EXPLANATION OF PROBLEM |
|---|-------|-------|------------------------|
| Constitutional Symptoms: | | | |
| Fever | _____ | _____ | _____ |
| Weight Loss | _____ | _____ | _____ |
| Ears, Nose and Throat: (Ear infection, sinus disease, etc...) | _____ | _____ | _____ |
| Cardiovascular (Heart/blood vessels): | | | |
| Chest Pain | _____ | _____ | _____ |
| Shortness of Breath | _____ | _____ | _____ |
| Respiratory (Lungs/Breathing): | | | |
| Coughing | _____ | _____ | _____ |
| Wheezing/asthma | _____ | _____ | _____ |
| Gastrointestinal (stomach/intestines): | _____ | _____ | _____ |
| Genitourinary (genitals/kidney/bladder): | _____ | _____ | _____ |
| Musculoskeletal (muscle/joint pain): | _____ | _____ | _____ |
| Dermatologic (Skin): | _____ | _____ | _____ |
| Neurologic: | _____ | _____ | _____ |
| Psychiatric: | _____ | _____ | _____ |
| Endocrine (Diabetes, thyroid disease, ...) | _____ | _____ | _____ |

PRIMARY DOCTOR _____

Do not write below this line

History reviewed by Physician: Physician's Signature: _____

Date: _____