Medical History Questionnaire

Patient Name: ________________________________ Date: ____________________

Date of Birth: ____________________ Date of last eye exam: ____________________

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

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

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Do you ***currently*** have any problems in the following areas? If **YES**, please provide additional information.	**YES**	**NO**	**Details**
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases? (**Circle all that apply**) **Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other heritable disease:**	**Yes**	**No**	**Unknown**

Social History

Does your vision limit any activities of daily activities of daily living (driving, reading, sports, work, etc.)?		**YES**	**NO**
Have you ever had a blood transfusion?		**YES**	**NO**
Do you drink alcohol?	If **YES**, how much?	**YES**	**NO**
Do you smoke?	If **YES**, how much?	**YES**	**NO**