# MEDICAL HISTORY QUESTIONNAIRE

Name Date

Date of Birth _____ Date of last eye exam _____

List any **medications** you currently take (Rx and over-the-counter): _____

Do you have **allergies** to any medications: YES NO

If YES, list the medications: _____

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

List any **surgeries** you have had (cataract, appendectomy):

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, ear ache, cough, dry mouth, etc.) | | | |
| **CARDIOVASCULAR** (high BP, racing pulse, etc.) | | | |
| **RESPIRATORY** (congestion, wheezing, short 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, hypothryoid, 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)? YES NO UNKNOWN

**Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis**

Other heritable disease:

## SOCIAL HISTORY

Does your vision limit any activties of daily living (driving, reading, sports, work, etc.)? YES NO

Have you ever had a blood transfusion?..... YES NO

Do you drink alcohol?..... YES NO If YES, how much? _____

Do you smoke?..... YES NO If YES, how much? How many years?

Family Physician _____ Pharmacy _____