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? _____

NAME _____ 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: _____