



MEDICAL HISTORY QUESTIONNAIRE

Date _____

Name _____ Date of Birth _____ Male Female

Primary Care Doctor _____ Referring Doctor (if different) _____

Pharmacy _____ Date of last eye exam _____

List any medications you currently take (Rx and/or over the counter): None See Attached List Daily Aspirin

MEDICATIONS	MG	#OF TIMES/ DAY

Height _____ Weight _____

DO YOU USE:

Tobacco: No Yes

How Much _____

Alcohol: No Yes

How Often _____

Recreation Drugs No Yes

Do you wear Contact Lenses? No Yes What Brand _____

Do you use Eye Drops/Ointment? No Yes Explain _____

Do you have any allergies to any medications or substances? YES NO
If YES, list the medications or substances and your reaction:

Reaction to Anesthesia? No Yes
Explain _____

Have you ever had an allergic reaction or any sensitivity to latex? NO YES Explain _____

List any surgeries you have had in the last 10 years (appendectomy, hysterectomy, gallbladder removal, etc.) and the year(s) they were performed:

SURGERY	YEAR	SURGERY	YEAR

Have any members of your family been diagnosed with any eye disease? NONE Diabetic Eye Disease Glaucoma Cataract
Macular Degeneration Retinal Detachment Crossed Eyes Blindness Serious Eye Injury Other _____

Have you ever been diagnosed with any eye disease? NONE Diabetic Eye Disease Cataract Glaucoma Lazy Eye
Macular Degeneration Retinal Detachment Iritis Crossed Eyes Blindness Serious Eye Injury

List any EYE SURGERIES or EYE INJURIES you have had and the year(s) they were performed. NONE

Type of Surgery	EYE	Year	Physicians Notes
	R L		
	R L		
	R L		

HEALTH HISTORY

Do you currently have any problems in the following areas? **If YES, please provide additional information.**

DISEASE	YES	NO	ADDITIONAL INFORMATION
GENERAL/CONSTITUTIONAL (Fever, heat stroke, weight loss, weight gain, fatigue)			
EAR, NOSE, THROAT (Hard of hearing, ear infection, sinus, chronic cough, dry mouth)			
CARDIOVASCULAR (High blood pressure, racing pulse, heart attack, heart disease, stroke, etc.)			
RESPIRATORY (Asthma, emphysema, COPD, shortness of breath, prolonged cough, wheezing, sputum production, etc.)			
GASTROINTESTINAL (Stomach ulcers, diarrhea, hernia, constipation, GERD, etc.)			
GENITAL, KIDNEY, BLADDER (Painful or frequent urination, dialysis, impotence, jaundice, etc.)			
MUSCLES, BONES, JOINTS (Arthritis, Sjogren's, joint pain, muscle aches, joint swelling, back pain, etc.)			
SKIN (Acne, cancer, psoriasis, eczema, etc.)			
NEUROLOGICAL (Bell's palsy, frequent headaches, double vision, weakness, difficulty walking, loss of balance, MS, tremors, dizziness, sleep apnea, loss of consciousness, seizures, etc.)			
PSYCHIATRIC (Anxiety, depression, hallucinations, memory loss, dementia, Alzheimer's, etc.)			
ENDOCRINE (Diabetes, thyroid disease, high cholesterol, etc.)			
BLOOD/LYMPH (Aids/HIV, anemia, leukemia, unexplained swelling or bruising, etc.)			
ALLERGIC/IMMUNOLOGIC (Seasonal allergies, hay fever symptoms, itching, frequent infections, Lupus, etc.)			
INFECTIOUS DISEASE (Hepatitis, herpes, tuberculosis,)			
OB/GYNECOLOGIC (Are you pregnant?)			
CANCER			

PATIENT NAME (please print) _____

Patient Signature

Date

OFFICE USE

Received by _____

Date