MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Date of last exam: _____

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

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 (concussion, etc.):

List any surgeries you have had, including the date (i.e. 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, earache, 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, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

RACE: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Other Pacific Islander Caucasian

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

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 activities of daily living (driving, reading, sports, work, etc.) ? **Yes** **No**

Do you drink alcohol? **Yes** **No** If YES, how much? _____

Do you smoke? **Yes** **No** If YES, how much? _____ How many years? _____