MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________ **DATE:**______________________________

Do you have **allergies** to any medications? Latex? or Seasonal? **YES or NO** if YES, please list.

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List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, cancer)

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List **date/surgeries** you have had (cataract, appendectomy, bypass) ______________________________

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MEDICATION LIST

Please list all **medications** you currently take (prescription & over the counter, including aspirin, vitamins, herbal supplements, blood thinners and eye drops.

MEDICATIONS			EYE DROPS

(Circle those that apply)

REVIEW OF SYSTEMS	YES	NO	DETAILS
GENERAL/CONSTITUTIONAL Fever, weight loss, cancer (list type)			
EARS, NOSE, THROAT stuffy nose, Cough, seasonal allergies			
CARDIOVASCULAR Heart disease, High blood pressure, heart attack, angina			
MUSCLES, BONES, JOINTS Joint pain Stiffness, arthritis, myasthenia gravis			
GASTROINTESTINAL upset stomach, Diarrhea, constipation			
GENITAL, KIDNEY, BLADDER Kidney stones, enlarged prostate, incontinence			
RESPIRATORY Asthma, emphysema			
SKIN Acne, rosacea, skin cancer			

Continued, If YES, provide details	YES	NO	DETAILS
NEUROLOGICAL (M5, stroke, headache, Migraines, aneurysm, dizziness			
PSYCHIATRIC Anxiety, depression			
ENDOCRINE Diabetes, thyroid			
BLOOD/LYMPH Anemia, cholesterol			
ALLERGIC/IMMUNOLOGIC Rheumatoid arthritis, Reynauid's, Sjogren's			

FAMILY HISTORY M=Mother F=Father S=Sibling GP=Grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Macular Degeneration			
Cancer			
Diabetes			
Heart Disease or Hypertension			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Arthritis			

SOCIAL HISTORY

	YES	NO	
Living arrangements			Live alone, live/w family, nursing home
Do you drive?			
Do you have difficulty driving?			
Do you have problems with night visior			
Do you wear contact lenses?			If YES, how many hours per day
Do you currently wear glasses?			Age of current prescription
Do you smoke?			Occasional Y. pk/day 1 pk/day 1+ pk/day
Do you drink alcohol?			Occasional 1/day 2-3/day 4+ /day

Use the reverse side if needed.

PLEASE BRINGTO YOUR APPOINTMENT ANY GLASSES AND/OR CONTACTS YOU ARE CURRENTLY WEARING.

Thank you for taking the time to complete this form.

Patient Signature: ______________________________ **Physician Signature:** ________________________