Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ /_____

Last Medical Exam: _____ / _____ / _____ Name of Medical Doctor: _____

Do you have any allergies to medications? ❒ no ❒ yes If yes, list drug and reaction: _____

_____

List any medications you take (including oral contraceptives, over the counter medications, vitamins, and supplements): _____

_____

_____

_____

List all major injuries, surgeries and / or hospitalizations you have had: _____

_____

Are you pregnant and / or nursing? ❒ no ❒ yes Height _____ Weight _____ lbs

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever	❒	❒	❒
Weight Loss	❒	❒	❒
Weight Gain	❒	❒	❒
CARDIOVASCULAR			
Heart Disease	❒	❒	❒
Chest Pain	❒	❒	❒
Irregular Heart Beat	❒	❒	❒
Congestive Heart Failure	❒	❒	❒
High Blood Pressure	❒	❒	❒
Pacemaker	❒	❒	❒
High Cholesterol	❒	❒	❒
Peripheral Artery Disease	❒	❒	❒
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Dry Throat / Mouth	❒	❒	❒
Ear Infections	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Shortness of Breath	❒	❒	❒
Chronic Cough	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
COPD	❒	❒	❒
Sarcoidosis	❒	❒	❒
Sleep Apnea	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Nausea	❒	❒	❒
Other_____	❒	❒	❒

	NO	YES	?
GENITOURINARY			
Urinary Tract Infections	❒	❒	❒
Kidney Failure	❒	❒	❒
Dialysis	❒	❒	❒
Gonorrhea	❒	❒	❒
Syphilis	❒	❒	❒
STD	❒	❒	❒
MUSCULOSKELETAL			
Arthritis	❒	❒	❒
Rheumatiod Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
Multiple Sclerosis	❒	❒	❒
INTEGUMENTARY (Skin Problems)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
Stroke	❒	❒	❒
PSYCHIATRIC	❒	❒	❒
ENDOCRINE			
Diabetes	❒	❒	❒
Thyroid	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
Sickle Cell Disease	❒	❒	❒
ALLERGIC DISORDERS	❒	❒	❒
IMMUNOLOGIC			
HIV / AIDS	❒	❒	❒
Lupus	❒	❒	❒

Please turn this form over and complete side two*

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

Do you use tobacco products? ❒ no ❒ yes If yes, type / amount / how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type / amount / how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type / amount / how long: _____

Ocular History

Last Eye Exam: _____ Name of Eye Doctor _____

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear sunglasses? ❒ no ❒ yes If yes, how often? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

List any eye surgeries you have had: _____

Do you have any of the following eye problems?

	NO	YES	?		NO	YES	?
Glaucoma	❒	❒	❒	Blurred Vision	❒	❒	❒
Cataract	❒	❒	❒	Double Vision	❒	❒	❒
Macular Degeneration	❒	❒	❒	Mucous Discharge	❒	❒	❒
Retinal Disease	❒	❒	❒	Redness	❒	❒	❒
Retina Detachment	❒	❒	❒	Sandy or Gritty Feeling	❒	❒	❒
Crossed Eyes	❒	❒	❒	Itching	❒	❒	❒
Amblyopia (Lazy Eye)	❒	❒	❒	Burning	❒	❒	❒
Dry Eyes	❒	❒	❒	Foreign Body Sensation	❒	❒	❒
Loss of Side Vision	❒	❒	❒	Excess Tearing / Watering	❒	❒	❒
Distorted Vision	❒	❒	❒	Glare / Light Sensitivity	❒	❒	❒
Halos	❒	❒	❒	Eye Pain or Soreness	❒	❒	❒
Styes	❒	❒	❒	Chronic Infection of Eye or Lid	❒	❒	❒
Floaters (Spots in Vision)	❒	❒	❒	Tired Eyes	❒	❒	❒
Discomfort in Windy Conditions	❒	❒	❒	Drooping Eyelid	❒	❒	❒

Do you work on a computer? ❒ yes ❒ no How many hours per day?_____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	❒	❒	❒	_____
Cataracts	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Disease	❒	❒	❒	_____
Blindness	❒	❒	❒	_____
Crossed Eyes	❒	❒	❒	_____
Amblyopia (Lazy Eye)	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Other Eye Disease_____	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
Hypertension	❒	❒	❒	_____
High Cholesterol	❒	❒	❒	_____
Kidney Disease	❒	❒	❒	_____
Stroke	❒	❒	❒	_____