# 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

Have you been diagnosed with or currently experience problems in any of 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 | ❒ | ❒ | ❒ | ______________ |