Medical History Questionnaire

Name: ______________________________ Date: ______________

Address: ______________________________ Date: ______________

City: ______________ State: ______ Zip: __________ Date: ______________

Guardian (If Applicable): ______________________ Date: ______________

Birth Date: ____/_____/_____ Social Security #: _____/______/_____ Phone: ______________

Occupation: ______________________________ Work Phone: ______________

Name of Medical Doctor: ______________________ Drs. Phone: ______________

Date of Last Medical Exam: ______________

Medical History

Do you have any allergies to any medications? ☐No ☐Yes If Yes, explain: ______________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

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

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
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment/Disease	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Lupus	☐	☐	
Thyroid Disease	☐	☐	
Other ______________	☐	☐	

*****Please turn this form over and complete the other side*****

Social History

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

☐ Yes, I would prefer to discuss my Social History information directly with the doctor.

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 recreational drugs? ☐No ☐Yes If yes, type/amount/how long: ______________________________

Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

Review of Systems

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

SYSTEM	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR / CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals / Kidney / Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle/Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

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