PATIENT MEDICAL HISTORY QUESTIONAIRE

(Please print.)

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

Birth Date: _______/______/______ Last Eye Exam: ____/_____/______ Last Medical Exam: ___/____/_____

Name of **Family Doctor**:____ Dr.'s Phone: ___________________

MEDICAL HISTORY:

Do you have **ANY ALLERGIES** (medications, seasonal etc)? Yes No **If yes** please list:_______________

____

List **ANY MEDICATIONS** you take (birth control, vitamins and any over the counter medications & home remedies.)

____

____

List all **major** illnesses, that you have (diabetes, high blood pressure, **glaucoma** etc) or injuries (i.e. concussions)

____

FAMILY HISTORY: (Please note any family history, parents, grandparents, siblings, children, living or deceased)

Disease	Yes	No	Unsure	Relation	Disease	Yes	No	Unsure	Relation
Blindness					Cancer				
Cataract					Heart Disease				
Crossed Eyes					High Blood Pressure				
Glaucoma					Kidney Disease				
Macular Degeneration					Other:				

SOCIAL HISTORY: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* ☐ Yes, I would like 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

Do you use tobacco products? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes Do you use illegal drugs? ☐ No☐ Yes

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphillis ☐ None

REVIEW OF SYSTEMS: Do you **currently** have any problems in the following areas:

System	Yes	No	System	Yes	No	System	Yes	No
Eyes			**Constitutional**			**Vascular / Cardiovascular**		
Loss of Vision			Weight Loss / Gain			High Blood Pressure		
Blur			Fever			Stroke		
Halos			**Integumentary (Skin)**			Heart Problems		
Double Vision			**Neurological (Headaches)**			**Genitourinary**		
Dryness			**Endocrine**			Kidney Disease		
Mucous Discharge			Thyroid			**Bones / Joints / Muscles**		
Redness			Diabetes			Arthritis		
Gritty / Sandy Feeling			**Ears, Nose, Throat, Mouth**			**Lymphatic / Hematologic**		
Itch			Sinus			Anemia		
Burn			**Respiratory**			**Allergic / Immunologic**		
Tearing			Asthma			Seasonal		
Pain			COPD			Medicine		
Flashes of Light			Bronchitis			**Psychiatric**		
Floaters			Emphysema			Depression		
Gastrointestinal						Anxiety		
Diarrhea / Constipation								

Other Health Problems not listed: ____

____ __________________ ______________ ____________

Patient / Guardian Signature Date Doctors Initials Date