

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Family Physician: _____

Do you have any allergies to any medications? YES NO- If yes, list the medications _____

List any medications you are currently taking (prescription and over the counter): _____

Do you currently have any problems in the following areas? If "YES", provide information:

System	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (Fever, Weight loss, Other)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
SKELETAL (Osteoporosis, arthritis)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL/PSYCHIATRIC (Anxiety, depression)			
BLOOD (Cholesterol, anemia, lupus, etc.)			

PAST EYE HISTORY AND RELATED SYSTEMIC CONDITIONS

Have you EVER been diagnosed with the following conditions? If "YES" indicate when diagnosed and treated.

Condition	YES	NO	Date Diagnosed and description of treatment
AGE RELATED MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
EYE INJURY			
EYE SURGERIES			
DIABETES			
HIGH BLOOD PRESSURE			
CANCER			
STROKE			
ARTHRITIS			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

Disease	YES	NO	Relationship to Patient
BLINDNESS			
MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
DIABETES			
CANCER			
OTHER			
UNKNOWN			

SOCIAL HISTORY

Do you smoke? Yes No

If yes-How many packs per day? _____

Do you wear? Glasses Contacts

Current Occupation: _____

Reviewed

Patients Initials

____/____/____

____/____/____

____/____/____

Patient's Signature

Date