

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: ___/___/___ Date of last eye examination: ___/___/___

List all Current Medications & strength (prescription and over the counter):

1 _____	7 _____
2 _____	8 _____
3 _____	9 _____
4 _____	10 _____
5 _____	11 _____
6 _____	12 _____

Do you have allergies to any medication? **Yes** **No** If "Yes", please list:

Medication	Reaction
1 _____	_____
2 _____	_____
3 _____	_____

Please mark the appropriate boxes below:

ILLNESS PAST AND PRESENT	DURATION		FAMILY HISTORY		RELATIONSHIP (mother, mother's mother, etc.)	
	YES	NO	YES	NO	YES	NO
Glaucoma						
Arthritis						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Stroke						
Thyroid Disease						
Asthma						
Hay Fever or Sinus						
Emphysema						
Others:						

List any **eye surgeries** you have had (*cataract, corneal transplant, etc.*):

List any **surgeries** you have had (*appendectomy, tonsillectomy, etc.*)

SOCIAL

Occupation: _____

Marital Status (please check one): Single Married Divorced Widowed

Do you drive: Yes No

Have you ever had a blood transfusion? Yes No If yes, what year? _____

Do you smoke? Yes No If yes, how many packs per day? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you currently have any problems in the following areas? If "Yes", please provide information.

Review of Systems (examples)	Yes	No	Explanation of Problem
EYES (glaucoma, cataracts, blurred vision)			
GENERAL (fever, weight loss, fatigue)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
CARDIOVASCULAR (chest pain, palpitations)			
RESPIRATORY (cough, shortness of breath, wheezing)			
GASTROINTESTINAL (nausea, vomiting, heartburn, loss of appetite)			
MUSCULOSKELETAL (joint pain, muscle weakness or pain)			
SKIN (rash, acne, skin cancer, warts)			
NEUROLOGICAL (headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
ENDOCRINE (diabetes, hypo/hyper-thyroid)			
HEMATOLOGIC (anemia, bleeding or bruising tendencies)			
ALLERGIC / IMMUNOLOGIC (hay fever, lupus)			

Office Use Only:

History reviewed: No Changes Changes as noted above

Date: ____/____/____

Doctor's Signature: _____

(Grutzmacher / Lewis / Sierra / Robinson)