MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of last eye exam: _____ / _____ / _____

Occupation: _____

MEDICAL DIAGNOSIS HISTORY

Diagnosis	Yes	No	Duration / Type
Allergies *(If yes, Please circle type)*	☐	☐	Seasonal / Environmental
Arthritis *(If yes, what type?)*	☐	☐	
Breathing Problem(s)	☐	☐	
Cancer *(If yes, what type?)*	☐	☐	
Cataracts	☐	☐	
Diabetes	☐	☐	
Glaucoma	☐	☐	
Headaches/Migraines	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
HIV/AIDS	☐	☐	
Kidney Disease	☐	☐	
Macular Degeneration (AMD)	☐	☐	
Stroke/CVA *(If yes, what year?)*	☐	☐	
Thyroid Disease *(If yes, Please circle type)*	☐	☐	Hyperthyroidism / Hypothyroidism
Have you ever had a Blood Transfusion?	☐	☐	*(if yes, what year?):*

MEDICATIONS *(Please list all current medications; prescription and over the counter as well as mg/dosage if known)*

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

Do you have any ***allergies*** to any medication? ☐ Yes ☐ No

(If yes, please list medication name and reaction)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SOCIAL HISTORY

	Yes	No	Formerly	Type/Year Quit	Usage *(daily/weekly)*
Do you use tobacco?	☐	☐	☐		
Do you consume Alcohol?	☐	☐	☐		
Do you consume Caffeine?	☐	☐			

SURGICAL HISTORY

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

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

MEDICAL HISTORY QUESTIONNAIRE CONTINUED

FAMILY MEDICAL HISTORY				
Diagnosis	**Yes**	**No**	**Relationship** *(Mother, Father, Sibling(s))*	**Type**
Amblyopia / Strabismus (Lazy Eye)	☐	☐		
Arthritis *(If yes, what type?)*	☐	☐		
Cancer *(If yes, what type?)*	☐	☐		
Cataracts	☐	☐		
Diabetes	☐	☐		
Glaucoma	☐	☐		
Heart Disease	☐	☐		
High Blood Pressure	☐	☐		
HIV/AIDS	☐	☐		
Kidney Disease	☐	☐		
Macular Degeneration (AMD)	☐	☐		
Stroke/CVA	☐	☐		
Thyroid Disease	☐	☐		

Do you **currently** have any problems in the following areas? *(If yes, please provide explanation)*

REVIEW OF SYMPTOMS (examples)	**Yes**	**No**	**Explanation of Problem**
Constitutional (fever, weight loss, fatigue)	☐	☐	
Ears, Nose, Throat (earaches, nose bleeds, sinus disease, sore throat)	☐	☐	
Respiratory (asthma, cough, shortness of breath, wheezing)	☐	☐	
Cardiovascular (chest pain, palpitations)	☐	☐	
Gastrointestinal (nausea, vomiting, heartburn, loss of appetite)	☐	☐	
Genitourinary (frequent urination, kidney stones, blood in urine)	☐	☐	
Endocrine (diabetes, hypothyroid)	☐	☐	
Neurological (headaches, paralysis, seizures, migraines)	☐	☐	
Psychiatric (depression, anxiety, memory loss)	☐	☐	
Skin (rash, acne, skin cancer, warts)	☐	☐	
Musculoskeletal (joint pain, muscle weakness, pain)	☐	☐	
Hematologic (anemia, bleeding or bruising tendencies)	☐	☐	
Allergic / Immunologic (hay fever, Lupus, seasonal allergies, Sjogren's)	☐	☐	