MEDICAL HISTORY QUESTIONNAIRE

Date_____ Date of Birth_____

Name_____ Male___ Female___ Soc. Sec.# _____
First Middle Last

Address_____ Home Phone_____ Cell Ph_____
Street City State Zip

Employer_____ Work Phone_____ E-Mail_____

Responsible Party_____Address_____Phone_____

Family Physician_____ Pharmacy_____

Insurance Company_____Policy Number_____

List any **medications** you currently take (prescription and over-the-counter):

_____

_____

Do you have any **allergies** to any medications? ____ YES ____ NO
If **YES**, list the medications:

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

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

_____

Women only: Are you currently **pregnant**? **YES_____ NO_____**

Do you ***currently*** have any problems, or ***use medication*** for any of the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating 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			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

GENERAL / CONSTITUTIONAL	YES	NO	Explanation of Problem
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, High BP, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Skin cancer, etc.)			
NEUROLOGICAL (MS, stroke, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			
FAMILY HISTORY			M=mother F-father S=sibling GP=grandparent
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation _____

Hobbies/Activities _____

Do you drink alcohol? ____YES _____NO If YES: occasional 1 per day 2-3 per day 4+ per day

Do you smoke? ____YES ____ NO If YES: occasional ½ pack/day 1 pack/day 1+pack/day

Patient's Signature_____ Date _____

Office Use Only

History Reviewed ____ No changes. ____ Additions as noted above. Dr's. signature _____