

## Medical History Questionnaire

Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_

Today's Date \_\_\_\_\_  
 Current Medical Doctor \_\_\_\_\_  
 Last Medical Exam \_\_\_\_\_

List any allergies or medicines or other substances: \_\_\_\_\_

List any medications you are taking (prescription or otherwise): \_\_\_\_\_

List any recent hospitalizations or surgeries: \_\_\_\_\_

**Review of Systems:** Do you currently, or have you ever had any problems in the following areas:

<u>System:</u>	<u>Yes</u>	<u>No</u>	<u>System</u>	<u>Yes</u>	<u>No</u>
<b>EYES</b>			<b>VASCULAR/HEART</b>		
Loss of vision	_____	_____	Diabetes	_____	_____
Blurred vision	_____	_____	High Blood Pressure	_____	_____
Double vision	_____	_____	Heart Disease	_____	_____
Redness	_____	_____	<b>NEUROLOGICAL</b>		
Burning	_____	_____	Headaches	_____	_____
Itching	_____	_____	Migraines	_____	_____
Light Sensitivity	_____	_____	Seizures	_____	_____
Tearing/Watery Eyes	_____	_____	<b>RESPIRATORY</b>		
Eye Injury	_____	_____	Asthma	_____	_____
Eye Surgery	_____	_____	COPD/Emphysema	_____	_____
Floater/Flashers	_____	_____	<b>SKIN DISORDER</b>		
Glare/Halos	_____	_____	<b>PSYCHIATRIC</b>		
Crossed or Lazy Eye	_____	_____	<b>IBS/ CROHN'S</b>		
Cataracts	_____	_____	<b>EAR/NOSE/THROAT/MOUTH</b>		
Glaucoma	_____	_____	Allergies/Hay Fever	_____	_____
Eye Pain/Soreness	_____	_____	<b>GENITOURINARY</b>		
Retinal Disease	_____	_____	Kidney/Bladder	_____	_____
<b>ENDOCRINE</b>			Genital	_____	_____
Thyroid	_____	_____	<b>SLEEPING DISORDER</b>		
<b>BONES/JOINTS/MUSCLES</b>			Sleep Apnea	_____	_____
Rheumatoid Arthritis	_____	_____	<b>HEMATOLOGIC</b>		
Joint/Back Pain	_____	_____	Anemia	_____	_____

**HAVE YOU HAD CANCER:** YES or NO Type \_\_\_\_\_

**PREGNANT/NURSING** YES or NO

**Social History:**

Do you drink alcohol? YES or NO HOW MUCH? \_\_\_\_\_

Do you use illegal drugs? YES or NO

Do you use tobacco products? YES or NO HOW MUCH? \_\_\_\_\_

Have you ever been exposed to or infected with: (circle)    Gonorrhea    Hepatitis    HIV    Syphilis    Other    NO TO ALL

**Family History:**

Please note any family history (parents, siblings, children) for the following conditions:

<b>OCULAR</b>	YES	NO	WHO	<b>SYSTEMIC</b>	YES	NO	WHO
Blindness	_____	_____	_____	Diabetes	_____	_____	_____
Glaucoma	_____	_____	_____	High Blood Pressure	_____	_____	_____
Macular Degeneration	_____	_____	_____	Cancer	_____	_____	_____
Retinal Detachment	_____	_____	_____	Heart Disease	_____	_____	_____
Crossed Eyes	_____	_____	_____				

REVIEWED BY (DOCTOR SIGNATURE) \_\_\_\_\_, OD

By signing this form, I consent to treatment for myself and/or on behalf of the minor to whom this information pertains. I give permission for the doctor to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of Minor and have the authority to authorize care and treatment.

PATIENT/GUARDIAN(signature) \_\_\_\_\_ Date \_\_\_\_\_