Medical History Questionnaire

Name _____ Today's Date _____
Birth 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:

System:	Yes	No
EYES		
Loss of vision	_____	_____
Blurred vision	_____	_____
Double vision	_____	_____
Redness	_____	_____
Burning	_____	_____
Itching	_____	_____
Light Sensitivity	_____	_____
Tearing/Watery Eyes	_____	_____
Eye Injury	_____	_____
Eye Surgery	_____	_____
Floater/Flashers	_____	_____
Glare/Halos	_____	_____
Crossed or Lazy Eye	_____	_____
Cataracts	_____	_____
Glaucoma	_____	_____
Eye Pain/Soreness	_____	_____
Retinal Disease	_____	_____
ENDOCRINE		
Thyroid	_____	_____
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	_____	_____
Joint/Back Pain	_____	_____

System	Yes	No
VASCULAR/HEART		
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
NEUROLOGICAL		
Headaches	_____	_____
Migraines	_____	_____
Seizures	_____	_____
RESPIRATORY		
Asthma	_____	_____
COPD/Emphysema	_____	_____
SKIN DISORDER	_____	_____
PSYCHIATRIC	_____	_____
IBS/ CROHN'S	_____	_____
EAR/NOSE/THROAT/MOUTH		
Allergies/Hay Fever	_____	_____
GENITOURINARY		
Kidney/Bladder	_____	_____
Genital	_____	_____
SLEEPING DISORDER		
Sleep Apnea	_____	_____
HEMATOLOGIC		
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, and children) for the following conditions:

OCULAR	YES	NO	WHO
Blindness	_____	_____	_____
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Retinal Detachment	_____	_____	_____
Crossed Eyes	_____	_____	_____

SYSTEMIC	YES	NO	WHO
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Cancer	_____	_____	_____
Heart Disease	_____	_____	_____

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_____

Patient Name: _____

Medication List: Many prescriptions can affect our eyes. Please list all medications, supplements and over the counter medications you are taking. Thank you.

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