MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Date of birth:_____ Date of last eye exam:_____

Reason for today's visit:_____

Medical doctor's name: _____ Pharmacy you use: _____

List current medical problems:_____

List current medications:_____

List past surgeries and procedures:_____

List all Eye Surgeries:_____

Allergies to medications:_____

List past major illnesses: _____

If yes provide explanation, if no please mark no. **(REVIEW OF SYSTEMS)**

Disease	**Yes**	**No**	**Explanation**
Eyes			
Loss of vision			
Blurred vision			
Loss of side vision			
Eye pain			
Any other			
General			
Fever			
Weight Loss			
Others			
Ears/Nose/Throat			
Cardiovascular/Heart/High B.P.			
Respiratory (c-pap, oxygen)			
Gastrointestinal (stomach, intestines)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints			
Neurological/Stroke (MS, Parkinson's)			
Psychiatric (anxiety, depression, bipolar)			
Endocrine / Diabetes			A1C: last blood sugar:
Others			

Immediate Family history: circle **DIABETES MACULAR DEGENERATION GLAUCOMA CANCER**

Ht._____ Wt._____ If female are you currently Pregnant?:_____ Due Date: _____

Social History

Current occupation_____ Marital status:_____

Do you smoke? _____ If yes how much? _____ Do you drink alcohol? _____ If yes how much? _____

Do you use recreational drugs? Yes No How often? _____ What type?_____

History reviewed:_____ Doctor's signature:_____

Updated:_____ Updated:_____ Updated:_____