MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ **DATE:**

Medical History

Do you have any allergies to medications? □ no □ yes If yes, please explain:

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):

List all major surgeries and/ or injuries you have had:

Review of Systems:

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	**NO**	**YES**
CONSTITUTIONAL		
Fever, Weight Loss/ Gain	□	□
INTEGUMENTARY (Skin)	□	□
NEUROLOGICAL		
Headaches	□	□
Migraines	□	□
Seizures	□	□
ENDOCRINE		
Thyroid/ other glands	□	□
EYES		
Loss of Vision	□	□
Blurred Vision	□	□
Distorted Vision/ Halos	□	□
Loss of Side Vision	□	□
Double Vision	□	□
Dryness	□	□
Redness	□	□
Itching	□	□
Burning	□	□
Excess Tearing	□	□
Glare / light sensitive	□	□
Eye Pain	□	□
Chronic Infection	□	□
Sties or chalazion	□	□
Flashes/ Floaters in vision	□	□
Tired Eyes	□	□
LYMPHATIC / HEMATOLOGIC		
Anemia	□	□
Bleeding Disorders	□	□
Cholesterol / Lipids	□	□

SYSTEM	**NO**	**YES**
EARS, NOSE, THROAT		
Allergies / Hay Fever	□	□
Sinus Congestion	□	□
Chronic Cough	□	□
Dry mouth / Throat	□	□
RESPIRATORY		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
VASCULAR / CARDIOVASCULAR		
Diabetes	□	□
Angina	□	□
Heart-attack	□	□
Stroke	□	□
High Blood Pressure	□	□
Vascular Disease	□	□
GASTROINTESTINAL		
Ulcers	□	□
Acid Reflux	□	□
Other _____	□	□
GENITOURINARY		
Genitals/ Kidney/ Bladder	□	□
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	□	□
Osteoarthritis	□	□
Muscle Pain	□	□
Other _____	□	□
ALLERGIES / IMMUNOLOGIC	□	□
PSYCHIATRIC		
Depression / Anxiety	□	□

If you answered YES to any of the above or have a condition not listed, please explain:

Please turn this form over and complete side two

EYE HISTORY

Have you ever had an injury or surgery to your eyes? □ no □ yes Explain:

Do you wear glasses? □ no □ yes
Do you wear contact lenses? □ no □yes
Type of contact lenses? □Soft □Rigid □Extended wear □Other
Contact Lens Solution?
Do you have a history of lazy eye? □ no □ yes Crossed eyes? □ no □yes

Have you ever been treated for glaucoma? □ no □ yes
Do you have macular degeneration? □ no □ yes
Do you use drops for your eyes? □ no □ yes Explain:

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings living or deceased) for the following conditions:

DISEASE/ CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	□	□	
Cataract	□	□	
Crossed Eyes	□	□	
Glaucoma	□	□	
Macular Degeneration	□	□	
Retinal Detachment / Disease	□	□	
Arthritis	□	□	
Diabetes	□	□	
Lupus	□	□	
Multiple Sclerosis	□	□	
Thyroid Disease	□	□	

SOCIAL HISTORY

Are you a smoker? □ no □ yes, if how much?
Do you drink alcohol? □ no □ yes
Do you use illegal drugs? □no □yes