Medical History Questionaire

Name: ____________________________ Date: ____________________________

Date of Birth: _______________________ Age: ___________________

Do you have any **ALLERGIES** to any medications: YES NO
If YES, please list the medications _______________________________________

Past Ocular History: Please list all eye conditions (glaucoma, cataracts, macular degeneration, lazy eye, etc.) including past surgeries and laser treatments. Please indicate which eye is involved.

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Past Medical History: Please list all major medical problems (Diabetes, high blood pressure, heart disease, cancer, stroke, asthma, COPD, etc)

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Past Surgical History: Please list all previous surgeries

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Medications: Please list all prescription and over the counter medications and dosages if known

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Family History: Please list diseases in your family (blindness, cancer, diabetes, high blood pressure, heart disease, stroke, etc.) and who was affected

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Social History:
Current occupation: ____
Education (high school graduate, vocational school, college degree): ____________________
Marital Status (married, divorced, single, widow): ________________________________
Do you drive: YES NO
Have you ever had a blood transfusion? YES NO
Do you drink alcohol: YES NO If yes: occasionally 1/day 2-3/day 4+/day
Do you smoke? YES NO If yes: occasionally ½ pack/day 1 pack/day 1+ pack/day

Review of Systems:
Do you currently have or have had any of the following problems? If yes, please explain

EYES	YES	NO	EXPLANATION
Loss of vision			
Blurred vision			
Distorted vision			
Flashers/Floaters			
Loss of side vision			
Double vision			
Dryness/Irritation/Redness			
Crossed eyes/Lazy eyes			
Eye trauma			
Tearing/Mucus discharge			
Eye pain			
GENERAL/CONSTITUTIONAL (fever, weight loss, malaise, etc.)			
EARS (hearing loss, ringing in the ears, infections, dizziness, etc.)			
NOSE (loss of smell, sinus problems, stuffy nose, nosebleeds, post nasal drip, etc.)			
THROAT (bleeding gums, chronic cough, problems chewing /swallowing, sore throat, etc.)			
LUNG/CHEST (persistent cough, coughing up blood, shortness of breath, wheezing, etc.)			
HEART (chest pain, irregular heartbeat, ankle swelling, blood clots, high blood pressure, etc.)			
GASTROINTESTINAL (Loss of appetite, upset stomach, constipation, diarrhea, bloody stools, black tarry stools, etc.)			
GENITAL/KIDNEYS/BLADDER (infections, painful urination, frequent urination, blood in urine, impotence, etc.)			
BONE/MUSCLE/JOINTS (joint pain, muscle pain, stiffness, swelling, etc.)			
SKIN (growths, persistent rash, sores, warts, etc.)			
NEUROLOGICAL (weakness, numbness, seizures, frequent headaches, fainting, etc.)			
PSYCHIATRIC (depression, anxiety, insomnia, mood swings, etc.)			
ENDOCRINE (diabetes, thyroid disorders, hypoglycemia, pituitary disease, etc.)			
BLOOD/LYMPH (anemia, leukemia, lymphoma, etc.)			
ALLERGIC/IMMUNOLOGIC (seasonal allergies, swelling, redness, itching, hives, lupus, etc.)			