



MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____

Name of physician referring you _____ Physician Phone _____

Physician Address _____ Date of last eye exam _____

Primary Medical Doctor (if different from above) _____

PAST HISTORY

What Eye medications do you use? _____

What Eye Surgeries have you had? _____

Do you currently wear glasses? _____ When was your last eye examination? _____

List any medications you take: _____

Please list any medications you are **ALLERGIC** to: _____

Please list any major illnesses and injuries: _____

Please list any other surgeries you have had: _____

FAMILY HISTORY

Do any of your relatives have these problems?

DISEASE	YES	NO	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Current occupation _____

Do you drink alcohol? YES NO

If YES, how many glasses a day? _____

Do you smoke? YES NO

If YES, how many packs a day? _____

Please answer the questions on the next page

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

	YES	NO	EXPLANATION OF PROBLEM
Ears, nose, mouth, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach/intestines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (bones, joints, muscles)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (rashes, lumps, bumps, redness, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (numbness, paralysis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (anxiety, depression, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (diabetes, thyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic/Lymphatic (anemia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic (AIDS, allergies)	<input type="checkbox"/>	<input type="checkbox"/>	_____

FOR PHYSICIAN USE ONLY

<input type="checkbox"/> History Reviewed	<input type="checkbox"/> No Changes	<input type="checkbox"/> Additions as noted above
PHYSICIAN'S SIGNATURE	DATE	