MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Family Doctor: _____ Phone #: _____

Date of Service: _____

FAMILY HISTORY

Note family member with the following: M-mother, F-father, S-sibling, GP-grandparent

[ ] Arthritis	Rel: _____	[ ] Cataracts	Rel: _____
[ ] Blindness	Rel: _____	[ ] Crossed Eyes	Rel: _____
[ ] Cancer	Rel: _____	[ ] Diabetes	Rel: _____
[ ] Glaucoma	Rel: _____	[ ] Heart Disease	Rel: _____
[ ] Hypertension	Rel: _____	[ ] Retinal Dz.	Rel: _____

SOCIAL HISTORY & HEALTH HABITS

Alcohol: [ ] Yes [ ] No Qty: ____ Tobacco: [ ] Yes [ ] No Qty: ____ Drugs: [ ] Yes [ ] No Qty: ____

REVIEW OF SYSTEMS

EYES	yes	no	unknown		yes	no	unknown
Blurred Vision	[ ]	[ ]	[ ]	Glare/Sensitivity	[ ]	[ ]	[ ]
Burning	[ ]	[ ]	[ ]	Glaucoma	[ ]	[ ]	[ ]
Cataracts	[ ]	[ ]	[ ]	Infection	[ ]	[ ]	[ ]
Crossed Eyes	[ ]	[ ]	[ ]	Itching	[ ]	[ ]	[ ]
Distorted Vision	[ ]	[ ]	[ ]	Lazy Eye	[ ]	[ ]	[ ]
Double Vision	[ ]	[ ]	[ ]	Loss of Vision	[ ]	[ ]	[ ]
Dryness	[ ]	[ ]	[ ]	Redness	[ ]	[ ]	[ ]
Eye Pain/Soreness	[ ]	[ ]	[ ]	Retinal Disease	[ ]	[ ]	[ ]
Flashes/Floaters	[ ]	[ ]	[ ]				
CANCER & ENDOCRINE							
Breast Cancer	[ ]	[ ]	[ ]	Prostate Cancer	[ ]	[ ]	[ ]
Lung Cancer	[ ]	[ ]	[ ]	Thyroid Abnormalities	[ ]	[ ]	[ ]
GENITOURINARY & REPRODUCTIVE							
Chlamydia	[ ]	[ ]	[ ]	Syphilis	[ ]	[ ]	[ ]
Gonorrhea	[ ]	[ ]	[ ]	Nursing Mother	[ ]	[ ]	[ ]
Kidney Disease	[ ]	[ ]	[ ]	Pregnant	[ ]	[ ]	[ ]
NEUROLOGIC & VASCULAR							
Epilepsy	[ ]	[ ]	[ ]	Diabetes	[ ]	[ ]	[ ]
Headaches	[ ]	[ ]	[ ]	Heart Disease	[ ]	[ ]	[ ]
Migraines	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]	[ ]	High Cholesterol	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	Stroke	[ ]	[ ]	[ ]

MEDICATIONS

Name	Purpose

Allergies: _____

Preferred Pharmacy: _____