Medical History Questionnaire

Patient's Name_____ Date_____

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Employer_____Occupation_____ Hobbies_____
When was your last eye exam?_____By whom?_____
When was your last medical exam?_____Who is your primary care physician?_____

Do you wear glasses?	No Yes	Do you drink alcohol?	No Yes _____drinks/week
Do you wear contacts?	No Yes	Do you smoke tobacco?	No Yes _____cigarettes/day
Do you drive?	No Yes	Do you use recreational drugs?	No Yes _____

Review of Systems
How is your general health? _____

Patient

		No	Yes	**Please Explain and List Medications with Associated Condition**
Eyes:	Loss of Vision	N	Y	_____
	Eye Injuries	N	Y	_____
	Eye Surgeries	N	Y	_____
	Glaucoma	N	Y	_____**Any Family Members with this condition?_____**
	Cataract	N	Y	_____Family Members?_____
	Macular Degeneration	N	Y	_____Family Members?_____
	Amblyopia (Lazy Eye)	N	Y	_____Family Members?_____
	Strabismus (Turned Eye)	N	Y	_____Family Members?_____
	Chronic Infection of Eye	N	Y	_____
	Flashes of Light in Vision	N	Y	_____
	Floaters in Vision	N	Y	_____
ENT:	Sinus Problems	N	Y	_____
	Seasonal Allergies	N	Y	_____
Cardiovascular:	Diabetes	N	Y	_____Family Members?_____
	High Blood Pressure	N	Y	_____Family Members?_____
	Heart Problems	N	Y	_____Family Members?_____
	High Cholesterol	N	Y	_____
Respiratory:	Asthma	N	Y	_____
	Emphysema	N	Y	_____
Gastrointestinal:	Ulcer	N	Y	_____
	Hepatitis	N	Y	_____
	Colon Polyps	N	Y	_____
Genitourinary:	Kidney Disorder	N	Y	_____
	Sex Transmitted Disease	N	Y	_____
Musculoskeletal:	Osteoarthritis	N	Y	_____
	Rheumatoid Arthritis	N	Y	_____Family Members?_____
	Multiple Sclerosis	N	Y	_____Family Members?_____
Integumentary:	Psoriasis	N	Y	_____
	Cold Sores	N	Y	_____
Neurological:	Headaches	N	Y	_____
	Seizures	N	Y	_____
Psychological:	Disorders	N	Y	_____
Endocrine:	Thyroid Disease	N	Y	_____Family Members?_____
Heme/Lymph:	Anemia	N	Y	_____
Allergy/Immun:	Systemic Lupus	N	Y	_____Family Members?_____
	Allergies to Medications	N	Y	_____

Major Injuries or Surgeries_____
Other general health or eye problems not covered: _____
Other medications or vitamins not listed above:

Office Use Only:
Date:_____Changes:_____O.D.initial_____
Date:_____Changes:_____O.D. initial_____
Date:_____Changes:_____O.D. initial_____
Date:_____Changes:_____O.D. initial_____
Date:_____Changes:_____O.D. initial_____