MEDICAL HISTORY QUESTIONNAIRE

Name Date of Birth Date

Do you have an Advance Directive for Healthcare? □ Yes □ No

List any **medication** you currently take (Rx and over-the-counter):	Do you have **allergies** to any medications? Yes No If YES, list the medications:

List any **surgeries** you have had (cataract, appendectomy, etc.):

Do you or your immediate family have any problems in the following areas? If YES, circle all that apply and provide additional information.

	You		Family		
	Yes	**No**	**Yes**	**No**	**Details**
EYES (blurry vision, dry eyes, watery eyes, pain, flashes, floaters, halos, headaches)					
Cataract					
Glaucoma					
Macular Degeneration					
Retina Detachment					
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)					
EARS, NOSE, THROAT (hard of hearing, stuffy nose, seasonal allergies, ear ache, cough, dry mouth, etc.)					
CARDIOVASCULAR (heart attack, high blood pressure, racing pulse, dizziness, etc.)					
RESPIRATORY (congestion, wheezing, short of breath, asthma, bronchitis, emphysema, etc.)					
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)					
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)					
FEMALES Are you pregnant? Nursing?					
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)					
SKIN (pimples, warts, growths, rash, etc.)					
NEUROLOGICAL (numbness, headache, seizures, paralysis, epilepsy, etc.)					
PSYCHIATRIC (anxiety, depression, insomnia)					
ENDOCRINE (diabetes, hypothyroid, etc.)					Diabetes controlled by: □ Insulin □ Pills □ Diet
BLOOD/LYMPH (bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.)					
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)					
OTHER (Cancer, AIDS, HIV+, Hepatitis, etc.)					

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
Have you ever had a blood transfusion? **YES** **NO** Date of last tetanus shot**:** _____
Do you drink alcohol? **YES NO** How much_____ Do you smoke? **YES NO** How much _____

OFFICE USE ONLY

Reviewed Date	Physician		Reviewed Date	Physician		Reviewed Date	Physician	Reviewed Date	Physician	