MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ Date: ______________

Date of Birth: __________________ Date of Last Exam: ______________

List all medications, including non-prescription, you currently take. If you cannot remember the name, write down the reason for the medication; for example: "blood pressure medicine, hormones, vitamin E."

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List any drug allergies: ________________________________

List any surgeries you have had: ____________________________

Do you currently have any problems in the following areas? If yes, please explain.

EYES ____

LOSS OF VISION______________________________________

BLURRED VISION ______________________________________

DOUBLE VISION______________________________________

DRYNESS ____

REDNESS ____

BURNING____

ITCHING____

FOREIGN BODY SENSATION_____________________________

SWOLLEN EYELIDS____________________________________

EYE PAIN ____

GENERAL____

FEVER____

WEIGHT-LOSS_______________________________________

OTHER ____

EAR, NOSE, OR THROAT ______________________________

HAYFEVER ____

SINUSITIS____________________

DRY COUGH OR DRY MOUTH____________________

CARDIOVASCULAR ____________________

HYPERTENSION OR HEART DISEASE ____________________

RESPIRATORY ____________________

GASTROINTESTINAL ____________________

GENITAL, KIDNEY, BLADDER ____________________

MUSCLES, BONES, JOINTS____________________

ARTHRITIS____________________

SJOGREN'S SYNDROME ____________________

SKIN ____________________

NEUROLOGICAL____________________

PSYCHIATRIC ____________________

ENDOCRINE____________________

DIABETES ____________________

THYROID ____________________

Have you ever had a blood transfusion? ☐ No ☐ Yes

FAMILY HISTORY (PLEASE INDICATE RELATIONSHIP OF PERSON TO PATIENT)

GLAUCOMA ____________________

DIABETES ____________________

CANCER ____________________

MACULAR DEGENERATION ____________________

HYPERTENSION ____________________

THYROID DISEASE ____________________

SOCIAL HISTORY

Current Occupation____________________

Education (high school, college, technical, etc.) ____________________

Marital Status__________Do you live in a nursing home or assisted living facility? ______

Do you wear contact lenses? _______ What type?________________How long? ______

Do you drink? ☐ No ☐ Yes If yes, then how much per day?____________________

Do you smoke? ☐ No ☐ Yes If yes, then how much per day? ____________________

Reviewed by (Dr.'s Initials)____________________Date ____________________