Medical History Questionnaire

Name _____ Today's Date: _____ / _____ / _____

Medical History

Do you have any allergies to medications ☐No ☐Yes If yes, please explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

_____

Have you ever had a reaction to anesthetics of any kind? ☐ No ☐ Yes If yes, please list _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury. Please list any other eye conditions:_____

_____

Are you pregnant and/or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐Rigid ☐Soft ☐Extended Wear ☐Other Are they comfortable? ☐Yes ☐No

Family/Personal History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	RELATIONSHIP				
	SELF	FATHER	MOTHER	SIBLING	OTHER
Cataracts	___	___	___	___	___
Blindness	___	___	___	___	___
Crossed Eyes	___	___	___	___	___
Glaucoma	___	___	___	___	___
Macular Degeneration	___	___	___	___	___
Retinal Detachment/Disease	___	___	___	___	___
Arthritis	___	___	___	___	___
Cancer	___	___	___	___	___
Diabetes	___	___	___	___	___
Heart Disease	___	___	___	___	___
High Blood Pressure	___	___	___	___	___
Kidney Disease	___	___	___	___	___
Lupus	___	___	___	___	___
Thyroid Disease	___	___	___	___	___
Other: _____	___	___	___	___	___

Please turn this form over and complete side two

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Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you smoke cigarettes? ☐ No ☐ Yes If yes, amount/how long:_____

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how often: ☐Daily ☐Weekly ☐Monthly

Do you use illegal drugs? ☐ No ☐ Yes If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM:	NO	YES
CONSTITUTIONAL		
Fever, weight loss/gain	☐	☐
INTEGUMENTARY (skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis-cough	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐
ENDOCRINE	☐	☐

If you answered yes to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____

Doctor's Signature **Date**

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