MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____

Referring physician (if any) _____ Today's Date _____

REVIEW OF SYSTEMS

Do you have any of the following problems?
(Please check only current problems. Medical History is on the following page).

Skin problems		Hay fever/allergies	
Headaches/migraines		Sinus congestion	
Loss of vision		Runny nose	
Blurred vision		Post-nasal drip	
Distorted vision/halos		Chronic cough	
Loss of side vision		Dry throat	
Dry eyes		Asthma	
Eye discharge		Bronchitis	
Red eyes		Emphysema	
Sandy/gritty eyes		Heart problems	
Itching/burning eyes		High blood pressure	
Eye pain/soreness		Thrombophlebitis(blood clots)	
Foreign body in eye		Arthritis	
Excess tearing		Muscle/joint pain	
Light sensitivity		Stroke	
Chronic eye infection		Swollen lymph nodes	
Stye/chalazion		Bleeding disorders	
Depression		Other	

Describe any major illnesses or injuries (including eye diseases): _____

Describe any surgeries/hospitalization within the last six (6) months: _____

FAMILY HISTORY/SOCIAL HISTORY

Describe the current health status or cause of death of your immediate family(parents, siblings, or children)

_____

_____

_____

Marital status:___ Single ___ Married ___ Divorced ___ Widowed

Occupation_____

Former occupation(If retired)_____

Tobacco Use _____How Much Daily _____

Alcohol Use _____How Much Daily _____

Illegal Drugs _____How Much Daily _____

Exercise _____How Much Daily _____

List medications including eye drops: _____

_____

_____

Are you allergic to any medications? If so, please list below. _____

_____

_____

Are you at risk for AIDS or other sexually transmitted diseases? ___Yes ___No

Have you or a close blood relative ever had any of the following?(Please check those that apply and describe in "remarks".)

Please check "Self" or "Relative" and state relationship in space provided.

	Self	Relative	Relationship		Self	Relative	Relationship
Blindness				Diabetes			
Cataract				Cancer			
Glaucoma				Heart attack			
Macular degeneration				High blood pressure			
Retinal detachment				Kidney disease			
Crossed eyes				Lupus			
Drooping eyelid				Sjogrens Syndrome			
Lazy eye				Stroke			
Arthritis				Thyroid disease			
Gout				Tuberculosis			
				Other (list below)			

Do you drive?_____Do you have difficulty driving?____Is Driver's License renewal necessary?_____

REMARKS: _____

_____

_____

_____

_____

HISTORY REVIEWED:

PHYSICIAN'S SIGNATURE **DATE** _____