Medical History Questionnaire

Name **Date**

List any current medications you use (Rx and OTC):
If you can provide list, we'll copy it for you.

Do you have allergies to any medications? YES NO
If YES, Please list the medications and the reactions:

List all major medical problems/ illnesses and/or injuries:

List any surgeries you have had:

Do you currently have any problems in the following areas?

If YES, please provide details.	YES	NO	DETAILS
EYES (blurred vision, pain, redness, etc)			
GENERAL/ CONSTITUTIONAL (fever, weight loss or gain, etc.)			
CARDIOVASCULAR (high bloood pressure, racing pulse, etc)			
EARS, NOSE, THROAT (hard of hearing, cough, dry mouth, etc.)			
RESPIRATORY (shortness of breath, wheezing, etc.)			
GASTROINTESTINAL (stomach, ulcers, diarrhea, etc.)			
GENITOURINARY (painful or frequent urination, impotence, etc)			
Females: Are you pregnant? Nursing?			
MUSCULOSKELETAL (joint pain, stiffness, swelling, etc.)			
INTEGUMENTARY (skin, rash, acne, growths, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, etc.)			
ENDOCRINE (diabetes, hypo or hyperthyroid, etc.)			
HEMATOLOGIC (anemia, bleeding, cholesterolemia)			
ALLERGIC/ IMMUNOLOGIC (sneezing, itching, hives, etc.)			

Family History	YES	NO	Mother	Father	Brother	Sister	Gmother	Gfather
Glaucoma								
Cataracts								
Macular Degeneration								
Eye Injury								
Retinal Disease								
Blindness								
Strabismus (Eye Muscle Problem)								
Amblyopia (Lazy Eye, Patching)								
Diabetes								
Cancer								
Heart Disease								
Other:								

Social History
Occupation: Hobbies:

Do you drink alcohol? NO	YES	rarely	1 per day	1-2/day	2+/day

Do you smoke? YES / NO	*(Circle Applicable Information)*		
Current every day smoker			
Current some days smoker	<1PPD	1PPD	1-3PPD
Smoker	Cigars	rarely	3+/week
Former Smoker	Pipe	rarely	3+/week
Never Smoker	Chewing Tobacco		

Physician's Signature

Date