MEDICAL HISTORY QUESTIONNAIRE TODAY'S DATE:_____

Name:_____ Birthdate:_____ Patient #_____

List any medications you currently take including over-the-counter medications & vitamins:

Name of med	Strength	dosage	Name of med	Strength	dosage
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you have any allergies to any medications? YES NO
If YES, list the medications:_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc) you have: _____
_____

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

Do you *currently* have any problems in the following areas? If YES, please provide additional info.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, 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, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)
Has any member of your family had the following diseases (circle all that apply)? YES NO UNKNOWN
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease?_____

SOCIAL HISTORY Have you ever had a blood transfusion? YES NO
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO
Do you drink alcohol? YES NO If YES, how much? _____
Do you smoke? YES NO If YES, how much? _____ How many years? _____

Patient / guardian (if child or disabled) signature _____ Date _____
Physician's signature _____ Date _____