MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ **Date** _____

Date of Birth _____ **Date of Last eye exam** _____

What **medications** do you currently take (prescription and over-the counter): _____

_____

Do you have **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** (eye injuries, concussion etc):

_____

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

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
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, anemia, high cholesterol, 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 any of the diseases below (circle all that apply)? **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Macular Degeneration, Diabetes, Hypertension, Heart Disease, Stroke, Cancer,

Thyroid Disease, Arthritis Other heritable diseases: _____

SOCIAL HISTORY
Does your vision limit any activities of daily living (driving, reading, sports, work, etc)? **YES** **NO**

Have you ever had a blood transfusion? **YES** **NO** Do you live alone? **YES** **NO**

Do you drink alcohol? **YES** **NO** If YES, how much? _____

Do you smoke? **YES** **NO** If YES, how much? _____ How many years? _____

Have you ever considered Laser Vision Correction? **YES** **NO**

PHYSICIAN'S Signature _____ *Date* _____

Dr. Jack Devore