Medical History Questionnaire

Date_____

Patient Name (please print) _____ Birth Date_____

Date of Last Eye Exam_____ **Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box.**

- ☐ Allergic/Immunologic
- ☐ Blood/Lymph/Cancer
- ☐ Cardiovascular
- ☐ Diabetes
- ☐ Ear/Nose/Throat
- ☐ Endocrine (Glands)
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Headaches/Migraines
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Musculoskeletal/Arthritis
- ☐ Nervous System Mental
- ☐ Respiratory
- ☐ Skin
- ☐ Surgeries (what type & when)_____

_____

Are you in good health? Yes No

Do you take medications? Yes No Please list names & how often_____

_____

_____

Any allergic reactions to medications or other substances? Yes No

If yes, please list_____

_____

Name of general physician_____Phone_____

Do you have any of the following? If Yes, please check box.

- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Eye Injuries
- ☐ Eye Surgeries
- ☐ Glaucoma
- ☐ Macular Degen.
- ☐ Retinal Detachment
- ☐ Wear Contacts
- ☐ Wear Glasses

Any other eye problems at this time? Please explain_____

_____

Please check Yes or No

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

Do you use other substances? Yes No

Do you have family history of any of the following? If Yes, please check box.

- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Macular Degen.
- ☐ Retinal Detachmt

Please explain any boxes you have checked _____

_____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature_____ Date_____