Medical History Questionnaire

Name:______________________ Today's Date:_________________

Birth Date:__________________ Last Medical Exam:_____________

Medical History

Current Medical Dr._____________________

List any allergies to medicines or other substances:____

List any medications you are taking (prescription or otherwise):______________________________

List any reasons for recent hospitalization or surgery:______________________________________

Review of Systems: Do you currently, or have you ever had any problems in the following areas:

System	Yes	No
Eyes		
Loss of vision	___	___
Blurred vision	___	___
Double vision	___	___
Eye injury	___	___
Eye surgery	___	___
Floaters/Flashes	___	___
Glare/Halos	___	___
Crossed or lazy eye	___	___
Cataracts	___	___
Glaucoma	___	___
Eye pain or soreness	___	___
Retinal disease	___	___
Endocrine		
Thyroid	___	___
Bones/Joints/Muscles		
Rheumatoid arthritis	___	___
Joint pain	___	___
Hematologic		
Anemia	___	___

System	Yes	No
Vascular/Heart		
Diabetes	___	___
High blood pressure	___	___
Heart pain	___	___
Neurological		
Headaches	___	___
Migraines	___	___
Seizures	___	___
Respiratory		
Asthma	___	___
Chronic bronchitis	___	___
Emphysema	___	___
Skin	___	___
Psychiatric	___	___
Gastrointestinal		
Diarrhea	___	___
Ear/Nose/Throat/Mouth		
Allergies/Hay fever	___	___
Genitourinary		
Kidney/Bladder/Genital	___	___

Social History

	Yes	No
Do you use tobacco products?	___	___
Do you use illegal drugs?	___	___

Pregnant? ___ ___

	Yes	No
Do you drink alcohol?	___	___

(how much?) _________________________

Have you been exposed or infected with: (circle) Gonorrhea Hepatitis HIV Syphilis

Family History

Please note any family history (parents, grandparents, siblings, and/or children – living or deceased) for the following conditions:

Ocular Condition	Yes	No
Blindness	___	___
Crossed eyes	___	___
Glaucoma	___	___
Macular degeneration	___	___
Retinal detachment	___	___

Systemic Condition	Yes	No
Diabetes	___	___
High blood pressure	___	___
Cancer	___	___
Heart Disease	___	___

Reviewed by: (Doctor's Signature)_______________________

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor/s to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of Minor and have the authority to authorize care and treatment:

Patient/Parent or Guardian_______________________________