Medical History Questionnaire

Name:______________________________ Today's Date:______________________________

Birth Date: __________________________ Current Medical Dr.__________________________

Medical History Last Medical Exam ________________________

List any allergies to medicines or other substances: ____

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

____

List any reasons for recent hospitalizations 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	___	___
Dry Eyes	___	___
Eye injury	___	___
Eye surgery	___	___
Floaters/Flashes	___	___
Glare/Halos	___	___
Crossed or lazy eye	___	___
Cataracts	___	___
Glaucoma	___	___
Eye pain/soreness	___	___
Retinal disease	___	___
Endocrine		
Thyroid	___	___
Bones/Joints/Muscles		
Rheumatoid arthritis	___	___
Joint/Back Pain	___	___
Hematologic		
Anemia	___	___

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

Social History

Do you use tobacco products? ___ ___ Do you drink alcohol? ___ ___

Do you use illegal drugs? ___ ___ (how much)______________________________

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

Family History

Please note any family history (parents, siblings, and or children) 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 signature): ____________________________O.D.

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 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 / Guardian (signature)________________________________