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	____	____
Redness	____	____
Burning	____	____
Itching	____	____
Light Sensitive	____	____
Excess Tearing/Watering Eyes	____	____
Eye Injury	____	____
Eye Surgery	____	____
Floaters/Flashers	____	____
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
Cancer	____	____
Type_____		
Vascular/Heart		
Diabetes	____	____
High Blood Pressure	____	____
Heart disease	____	____
Neurological		
Headaches	____	____
Migraines	____	____
Seizures	____	____
Respiratory		
Asthma	____	____
COPD/Emph	____	____
Skin Disorder	____	____
Psychiatric	____	____
IBS/Crohn's	____	____
Ear/Nose/Throat/Mouth		
Allergies/Hay fever	____	____
Genitourinary		
Kidney/Bladder	____	____
Genital	____	____
Sleeping Disorders		
Sleep Apnea	____	____

Social History

Do you use tobacco products?	____	____
Do you use illegal drugs?	____	____
Do you drink alcohol?	____	____

(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	____	____
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 to whom 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):_____