

## 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:

<u>System</u>	Yes	No	<u>System</u>	Yes	No
<b>Eyes</b>			<b>Vascular/Heart</b>		
Loss of vision	___	___	Diabetes	___	___
Blurred vision	___	___	High blood pressure	___	___
Double vision	___	___	Heart pain	___	___
Eye injury	___	___	<b>Neurological</b>		
Eye surgery	___	___	Headaches	___	___
Floaters/Flashes	___	___	Migraines	___	___
Glare/Halos	___	___	Seizures	___	___
Crossed or lazy eye	___	___	<b>Respiratory</b>		
Cataracts	___	___	Asthma	___	___
Glaucoma	___	___	Chronic bronchitis	___	___
Eye pain or soreness	___	___	Emphysema	___	___
Retinal disease	___	___	<b>Skin</b>	___	___
<b>Endocrine</b>			<b>Psychiatric</b>	___	___
Thyroid	___	___	<b>Gastrointestinal</b>		
<b>Bones/Joints/Muscles</b>			Diarrhea	___	___
Rheumatoid arthritis	___	___	<b>Ear/Nose/Throat/Mouth</b>		
Joint pain	___	___	Allergies/Hay fever	___	___
<b>Hematologic</b>			<b>Genitourinary</b>		
Anemia	___	___	Kidney/Bladder/Genital	___	___

### Social History

Do you use tobacco products? \_\_\_

Do you drink alcohol? \_\_\_

Do you use illegal drugs? \_\_\_

(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:

<u>Ocular Condition</u>	Yes	No	<u>Systemic Condition</u>	Yes	No
Blindness	___	___	Diabetes	___	___
Crossed eyes	___	___	High blood pressure	___	___
Glaucoma	___	___	Cancer	___	___
Macular degeneration	___	___	Heart Disease	___	___
Retinal detachment	___	___			

**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 \_\_\_\_\_