Medical History Questionnaire

Today's Date:___/___/______

Name:____ Date of Birth:___/___/______

Current Medical Doctor/PCP:____

Medical History (please complete the medication list form included, also)

Do you have any allergies to any medications? ❑Yes ❑No Please list:_______________

____

List all major injuries, surgeries and/or hospitalizations you have had:___________________

____

Are you pregnant or nursing? ❑Yes ❑No

If yes, please indicate due date/delivery date: ___/___/______

What hobbies or recreational activities do you enjoy? ______________________________

____

Family History

Have any of your relatives (parents, grandparents, children), living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Relationship to you
Blindness	❑	❑	________________
Cataract	❑	❑	________________
Crossed Eyes	❑	❑	________________
Glaucoma	❑	❑	________________
Macular Degeneration	❑	❑	________________
Retinal Detachment	❑	❑	________________
Retinal Disease	❑	❑	________________
Systemic Disease/Condition			
Arthritis	❑	❑	________________
Cancer	❑	❑	________________
Diabetes	❑	❑	________________
Heart Disease	❑	❑	________________
High Blood Pressure	❑	❑	________________
Kidney Disease	❑	❑	________________
Lupus	❑	❑	________________
Thyroid Disease	❑	❑	________________
Other:___________________	❑	❑	________________

Please complete the other side of this form

Social History

Do you drive? ❑Yes ❑ No — If yes, do you have visual difficulty when driving? ❑Yes ❑ No

Do you use tobacco?: ❑Yes ❑ No — Cigarettes/Cigars? ❑ Smokeless? ❑ Vape/Juul? ❑

Do you drink alcohol? ❑Yes ❑ No — Beer ❑ Wine ❑ Liquor ❑ / Occasionally ❑ Socially ❑ Daily ❑

Do you use illicit drugs? ❑Yes ❑No

Review of Systems

Do you have now, or have you had recently, any of the following problems?

Eyes	Yes	No
Previous Surgery	❑	❑
Contact Lenses	❑	❑
Pain	❑	❑
Double Vision	❑	❑
Glaucoma	❑	❑
Cataracts	❑	❑
Macular Degeneration	❑	❑
Dry Eyes	❑	❑
Flashes	❑	❑
Floaters	❑	❑
Glare/Light Sensitivity	❑	❑
Burning Itching	❑	❑
Ear, Nose and Throat		
Hard of Hearing	❑	❑
Ringing of Ears	❑	❑
Vertigo	❑	❑
Allergies/Hay Fever	❑	❑
Cardiovascular		
Chest Pain	❑	❑
Dizziness	❑	❑
Fainting Spells	❑	❑
Shortness of Breath	❑	❑
Irregular Heart Beat	❑	❑
Difficulty Lying Flat	❑	❑
High Blood Pressure	❑	❑
Stroke/Brain Injury	❑	❑
Constitutional		
Fatigue/Weakness	❑	❑
Fever	❑	❑
Unexpected Weight Change	❑	❑
Respiratory		
Cough	❑	❑
Congestion	❑	❑
Wheezing	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Gastrointestinal		
Heartburn	❑	❑
Nausea/Vomiting	❑	❑
Jaundice/Hepatitis	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑

Genito-Urinary	Yes	No
Pain/Difficulty Urinating	❑	❑
Blood in Urine	❑	❑
History Kidney Stones	❑	❑
History STD's	❑	❑
Glaucoma		
Psychiatric		
Anxiety/Depression	❑	❑
Mood Swings	❑	❑
Difficulty Sleeping	❑	❑
Endocrine		
Increased Thirst	❑	❑
Increased Urination	❑	❑
Increased Urination	❑	❑
Increased Sweating	❑	❑
Fingernail Changes	❑	❑
Diabetes	❑	❑
Thyroid Disease	❑	❑
Blood/Lymph		
Easy Bruising	❑	❑
Gums Bleed Easily	❑	❑
Prolonged Bleeding	❑	❑
Heavy Aspirin/NSAID Use	❑	❑
Anemia	❑	❑
MusculoSkeletal		
Stiffness	❑	❑
Arthritis	❑	❑
Joint Pain/Swelling	❑	❑
Skin		
Rash/Sores	❑	❑
Lesions	❑	❑
Hives/Eczema	❑	❑
Neurological		
Seizures	❑	❑
Weakness/Paralysis	❑	❑
Numbness	❑	❑
Tremors	❑	❑
Headaches	❑	❑
Migraines	❑	❑
Immunologic		
Hives	❑	❑
Itching	❑	❑
Runny Nose	❑	❑
Sinus Pressure	❑	❑
HIV	❑	❑
Hepatitis	❑	❑