

Medical History Questionnaire

Name: _____ Age: _____ Date: _____

Date of last Eye Exam: _____ Name of last Eye Doctor: _____

Name of Primary Care Physician: _____

List any medications you are currently taking (include prescription and over the counter meds, birth control pills, hormones, herbal remedies and vitamins): _____

Are you allergic to any medication? Yes No If yes, please list: _____

List any surgeries you may have had: _____

Are you pregnant or nursing? If yes, how many months? _____

General Health Problems Past or Present	Yes	No	Describe
Eyes (blur, pain, vision loss, discharge, etc.)			
Constitutional (fever, fatigue, weight loss/gain, etc.)			
Ears, Nose, Throat (sinus, hearing loss, chronic cough, etc.)			
Cardiovascular (high blood pressure, stroke, heart disease, etc.)			
Respiratory (asthma, emphysema, etc.)			
Kidney, Bladder, Genital			
Muscles, Bones, Joints (arthritis, osteoporosis, etc.)			
Skin (herpes, acne, skin cancer, etc.)			
Endocrine (diabetes, thyroid, etc.)			
Allergic/Immunologic (hayfever, lupus, rheumatoid, etc.)			
Blood/Lymph (high cholesterol, anemia, HIV, AIDS, etc.)			
Neurological (Multiple Sclerosis, Parkinson's, etc.)			
Psychiatric (depression, anxiety, etc.)			
Family History	Yes	No	Relationship to Patient
Eye Disease (glaucoma, cataracts, macular degeneration, etc.)			
Diabetes			
Heart Disease, High Blood Pressure			
Cancer			
Stroke			
Other			
Social History	Yes	No	Describe
Hobbies			
Do you or have you ever worn contact lenses?			If yes, what brand?
Would you like to be fitted for contact lenses?			
Do you drink alcohol?			How much?
Do you smoke?			How much?

I attest that the above information is accurate and true to the best of my knowledge.

Signature _____ Date _____

(If patient is under 18, parent or legal guardian must sign)