Medical History Questionnaire

Last Name:	First Name:
Occupation/Education:	Name of Medical Doctor:
Current Weight: _____ lbs	Current Height: _____ ft _____ in
Are you currently pregnant or nursing? Not Applicable No Pregnant Nursing	

Social History

Do you currently smoke or have you in the past?

☐ Never Smoker ☐ Former Smoker ☐ Current Smoker: _____ # packs/day

Do you drink alcohol?

☐ No ☐ Rarely ☐ Moderately ☐ Socially ☐ Daily: _____ # drinks/day

Do you use any other types of drugs or take any prescription medications not prescribed for you?

☐ No ☐ Yes: type of drug/amount/frequency: _____

Medications/Allergies

Please indicate whether you use the following, and if so, the name/dosage of the medication.

Eye Drops: ☐ No ☐ Yes

If yes: name of eye drops: _____

Prescriptions (**Rx**): ☐ No ☐ Yes

If yes: name of Rx/dosage: _____

_____

Over the Counter: ☐ No ☐ Yes

If yes: name/dosage: _____

Do you have any **allergies to medications**? ☐ No ☐ Yes

If yes: name of medication(s) and reaction: _____

Do you have any **food allergies?** ☐ No ☐ Yes

If yes: what food(s) and reaction: _____

Eye Health History

Have you had any eye surgeries (e.g. Lasik, Cataract Removal, Eyelid Lift, etc)? ☐ No ☐ Yes

If yes: please list the procedure, date, and Dr. that performed the surgery: _____

_____

Do you wear glasses? ☐ No ☐ Yes If yes: how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes: what brand of lenses do you wear? _____

*please turn over to complete side two

REVIEW OF SYMPTOMS

Please select any of the following symptoms that your are experiencing (**controlled with or without the use of medication**):

SYSTEM	No	Yes
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Eyes		
Blurred Vision	☐	☐
Loss of Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Watering/Tearing	☐	☐
Glare/Light Sensitivity	☐	☐
Halos/Flashes/Floaters	☐	☐
Ear, Nose, Throat		
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Cough/Chronic	☐	☐
Dry Throat/Mouth	☐	☐
Sore Throat	☐	☐
Cardiovascular		
Coronary Artery Disease	☐	☐
Congestive Heart Failure	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Respiratory		
Asthma	☐	☐
Bronchitis/Chronic	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐
Emphysema	☐	☐

	No	Yes
Gastrointestinal		
Stomach Ulcers	☐	☐
GERD (Acid Reflux)	☐	☐
Genitourinary		
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Arthritis/Rheumatoid/Osteo	☐	☐
Joint Pain	☐	☐
Muscle Pain	☐	☐
Integumentary (Skin)		
Psoriasis	☐	☐
Eczema	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Mental Illness	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid Disease	☐	☐
Hematologic/Lymphatic		
Bruise Easily	☐	☐
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergies (seasonal or year-round)	☐	☐

If you answered yes to any of the above, please explain:

_____

_____

_____

_____

FAMILY HISTORY

If any **BLOOD** relative (**GRANDPARENTS, PARENTS, SIBLINGS ONLY**) has any of the following conditions, please indicate so and provide the relationship to you.

☐ **ADOPTED**- NO FAMILY HISTORY

DISEASE/CONDITION	No	Yes	Relationship to you
Amblyopia (lazy eye)	☐	☐	
Cataracts	☐	☐	
Blindness	☐	☐	
Glaucoma	☐	☐	
Retina (Macular Degeneration)	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
Hypertension	☐	☐	
Kidney Disease	☐	☐	
Lupus	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	

Patient Signature: _____ Date: _____