MEDICAL HISTORY QUESTIONNAIRE

Date: _____ **Name:** _____ **Birthdate:** _____ **Family Physician:** _____

Do you *currently* have any problems in the following areas? If "YES", provide information:

System	YES	NO	Explanation of problem
GENERAL/CONSTITUTIONAL (Fever, weight loss, other)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, hypertension)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
SKELETAL (Osteoporosis, arthritis)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL/PSYCHATRIC (Anxiety, depression)			
BLOOD (Cholesterol, anemia, lupus, etc.)			

Are you currently experiencing: flashes of light _____ floaters _____

PAST EYE HISTORY AND RELATED SYSTEMIC CONDITIONS

Have you EVER been diagnosed with the following conditions? If "YES" indicate when diagnosed and treated.

Condition	YES	NO	Date diagnosed and description of treatment
AGE RELATED MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
EYE INJURY			
EYE SURGERIES			
DIABETES			
HIGH BLOOD PRESSURE			
CANCER			
STROKE			
ARTHRITIS			

Medications: (List all medications & vitamins you take regularly and the medical reason)

_____

_____

_____

_____

_____

Allergies: (List any allergies to medications, foods or other allergens)

_____

_____

FAMILY HISTORY

M=mother F=father S=sister B=brother A=aunt U=uncle MGM=maternal grandmother MGF=maternal grandfather PGM=paternal grandmother PGF=paternal grandfather

Condition	YES	NO	Relationship to Patient
BLINDNESS			
MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
DIABETES			
CANCER			
OTHER			
UNKNOWN			

Reviewed **Patients Initials**

___/___/___ _____

___/___/___ _____

___/___/___ _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

If yes - How many packs per day? _____

If no - Are you a former smoker? ☐ Yes ☐ No

Alcohol use: ☐ None ☐ Social only
☐ 1-2 drinks a day ☐ Above average use

Do you wear? ☐ Glasses ☐ Contacts

What color are your eyes? _____

Current Occupation: _____

_____ _____

Patient's Signature Date