Medical History Questionnaire

Past Medical History

Are you allergic to any medications? No ☐ Yes ☐ If Yes, please list.

____

Please list all medications you take (including oral contraceptives, aspirin and over the counter medications):

____

Please list any major surgeries, hospitalizations or injuries you have had in the last year:

____

Personal and Family Medical History

Do you or any living or deceased blood relative (parents, grandparents, siblings) have the following conditions?

DISEASE/CONDITION	SELF NO	SELF YES	FAMILY NO	FAMILY YES	RELATIONSHIP TO YOU
Glaucoma	☐	☐	☐	☐	
Cataracts	☐	☐	☐	☐	
Macular Degeneration	☐	☐	☐	☐	
Eye Injury	☐	☐	☐	☐	
Retinal Disease	☐	☐	☐	☐	
Blindness	☐	☐	☐	☐	
Strabismus	☐	☐	☐	☐	
Amblyopia	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Dry Eye	☐	☐	☐	☐	

Social History

Occupation: ______________________________

Do you use tobacco products? No ☐ Yes ☐

Do you use recreational drugs? No ☐ Yes ☐

Do you use alcohol? No ☐ Yes ☐

Eye Surgical History: Date: ________ Surgeon: ____________ Procedure: ____________ Eye:_______

Review of Systems

Do you have any significant problems in the following areas?

Ears, Nose, Throat: Sinus trouble, Loss of Balance, etc.

____

Respiratory: Asthma, Bronchitis, Emphysema, etc.

____

Gastrointestinal: Ulcers, Nausea, Abdominal Pain, etc.

____

Genitourinary: Kidneys, Bladder, Ovaries, Prostate, etc.

____

Musculoskeletal: Arthritis, MS, Muscular Dystrophy, etc.

____

Hematologic/Lymphatic: Blood Disorders, etc.

____

Neurological: Migraines, Bell's Palsy, Shingles, etc.

____

Allergic/Immunologic: Allergies, HIV, etc.

____

Psychiatric: Depression, Drug Dependency, etc.

____

Constitutional: Fever, Sudden Weight Loss/Gain, etc.

____

Integumentary: Skin Cancer, Rashes, New Growths, etc.

____

Cardiovascular: Blood Pressure, Heart Attack, etc.

____

Endocrine: Thyroid, Diabetes Type I or II? If yes please note Physician, blood sugar and A1C Value if known.

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