Medical History Questionnaire

Review of Systems

Do you presently have any problems in the following areas?

	Yes	No
Ears, nose, mouth, throat	❑	❑
Cardiovascular (heart/blood vessels)	❑	❑
Respiratory (lungs/breathing)	❑	❑
Gastrointestinal (stomach/intestines)	❑	❑
Genitourinary (genitals/kidney/bladder)	❑	❑
Musculoskeletal (muscles/joints)	❑	❑
Integument (skin)	❑	❑
Neurological	❑	❑
Psychiatric (anxiety, depression)	❑	❑
Endocrine (hormones, glands)	❑	❑
Hematologic/Immunological (blood)	❑	❑
Seasonal allergies (hay fever, cedar etc)	❑	❑

Eyes	Yes	No
Loss or blurred vision	❑	❑
Loss of side vision	❑	❑
Double vision	❑	❑
Itching, burning, or discharge	❑	❑
Redness	❑	❑
Gritty feeling, dryness or tearing	❑	❑
Light sensitivity	❑	❑
Eye pain or soreness	❑	❑
Infection of eyelashes or eyelids	❑	❑
Glare/halos	❑	❑

Patient Ocular History

Mark Yes or No to each question

Age-related macular degeneration	❑ Yes	❑ No
Lazy eye/Eye turn	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Eye surgery	❑ Yes	❑ No
Injury to eye	❑ Yes	❑ No

List eye drops currently using:

____

____

____

Patient Medical History

Mark Yes or No to each question

Diabetes mellitus	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No
High cholesterol	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
AIDS/HIV	❑ Yes	❑ No

List any conditions not mentioned above:

____

____

____

Family History

Mark Yes or No to each entry. If Yes, list which family member (mother, father brother, sister etc)

Blindness	❑ Yes	❑ No	____________
Cataract	❑ Yes	❑ No	____________
Macular Degeneration	❑ Yes	❑ No	____________
Glaucoma	❑ Yes	❑ No	____________
Retinal Detachment	❑ Yes	❑ No	____________
Diabetes	❑ Yes	❑ No	____________
Hypertension	❑ Yes	❑ No	____________
Cancer	❑ Yes	❑ No	____________
Arthritis	❑ Yes	❑ No	____________

Other: ______________________________

Medications

List all current medications that you are currently using:

____

____

____

____

Medication Allergies

List any allergies to medication (ie penicillin, sulfa) below

____

____

Social History

Do you use tobacco products?	❑ Yes	❑ No	How much per day? ____________________
Do you drink alcohol?	❑ Yes	❑ No	How often? ____________________
Have you ever had a blood transfusion?	❑ Yes	❑ No	When? ____________________

Patient's Signature: ______________________________ Date: ______________

Physician's Signature: ______________________________ Date: ______________

If there are no changes in your history since your last visit, initial and date here: ____________________