

# Medical History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_

Who is your family physician? \_\_\_\_\_ Other doctors: \_\_\_\_\_

**ALLERGIES:** Do you have any allergies to *medications, food, or seasonal allergies*?  no  yes

If yes, explain: \_\_\_\_\_

**MEDICATIONS:** List all medications you take (including oral contraceptives, aspirin, over the counter medications, vitamins):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOUR PAST OCULAR HISTORY:** Do you or have you had any eye health problems such as *glaucoma, cataracts, eye injury or surgery, crossed or "lazy" eye, or any other problem with your eyes or vision*?  no  yes If yes, please list:

Disease / Condition	Date diagnosed?	Disease / Condition	Date diagnosed?
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_____	_____	_____	_____
_____	_____	_____	_____

**YOUR GENERAL HEALTH HISTORY:** Do you or have you had *diabetes, high blood pressure, arthritis, asthma, heart disease, or any other health problems*?  no  yes If yes, please list:

Disease / Condition	Date diagnosed?	Disease / Condition	Date diagnosed?
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_____	_____	_____	_____
_____	_____	_____	_____

List all major *injuries, surgeries and/or hospitalizations* you have had:

\_\_\_\_\_

Are you pregnant and/or nursing?  no  yes

**SOCIAL HISTORY:** *This information is kept confidential. However, you may discuss this privately with the doctor.*

Do you use tobacco, drink alcohol, or have you ever been exposed to or infected with a sexually transmitted disease?  no  yes

Explain: \_\_\_\_\_

**FAMILY'S OCULAR HEALTH HISTORY:** Please note any family history (parents, grandparents, siblings, children, etc.) of *glaucoma, cataracts, crossed or "lazy" eyes, macular degeneration, or other eye health problems*:

Disease / Condition	Relationship	Disease / Condition	Relationship
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_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY'S GENERAL HEALTH HISTORY** Please note any family history (parents, grandparents, siblings, children, etc.) of *diabetes, high blood pressure, arthritis, asthma, heart disease, or any other health problems*:

Disease / Condition	Relationship	Disease / Condition	Relationship
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_____	_____	_____	_____
_____	_____	_____	_____

## REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:  no  yes If yes, circle those that apply:

**CONSTITUTIONAL** (fever, weight loss/gain)

**EARS, NOSE, MOUTH, THROAT**

**GASTROINTESTINAL** (bowel)

**LYMPHATIC, HEMATOLOGIC** (blood)

**PSYCHIATRIC**

**INTEGUMENTARY** (skin)

**RESPIRATORY**

**GENITOURINARY** (genitals/kidney)

**ENDOCRINE** (thyroid/other glands)

**NEUROLOGICAL** (headaches, seizures)

If yes, circle those that apply:

**IMMUNOLOGIC**

**VASCULAR, CARDIOVASCULAR,**

**BONES, JOINTS, MUSCLES**

**ALLERGIC**

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Med Hx (for website) 3-20-08 DrM laptop