PATIENT MEDICAL HISTORY QUESTIONNAIRE

Please complete this form as accurately and comletely as possible. Please print. Thank you	
Today's Date	
Patient Name (Last, First, MI)	
Patient's Date of Birth	
Patient's Medical Doctor	
Patient's Occupation	
Patient Height and Weight	feet inches pounds

Please list all current medications, including eye drops and non-prescription medications, in the space below.

Please list all allergies to medications, foods and seasonal.

Please list all surgeries and major injuries.

Please indicate if you (the patient) or a family member (parent, grandparent, brother, sister) ever had the following conditions. Please circle any conditions that apply.	Patient		Family Member	
	Yes	No	Yes	No
01. Amblyopia, crossed or lazy eye?				
02. Cataracts?				
03. Eye infection?				
04. Eye injury?				
05. Glaucoma?				
06. Macular degeneration?				
07. Cardiovascular problems PLEASE CIRCLE (high blood pressure, high cholesterol, heart disease, arrhythmia, etc.)?				
08. Endocrine problems PLEASE CIRCLE (Diabetes, high/low thyroid, etc.)?				
09. Neurological problems PLEASE CIRCLE (stroke, numbness, weakness, headaches, paralysis, seizures, etc.)?				
10. Ear, nose, mouth/throat problems PLEASE CIRCLE (hearing loss, sinus problems, sore throat, etc.)?				
11. Gastrointestinal/liver problems PLEASE CIRCLE (heartburn, abdominal pain, Cirrhosis, Hepatitis, etc.)?				
12. Genital/urinary problems PLEASE CIRCLE (discharge, pain, blood in urine, etc.)?				
13. Blood or lymph problems PLEASE CIRCLE (Anemia, Leukemia, HIV/AIDS, etc.)?				
14. Skin problems PLEASE CIRCLE (rashes, excessive dryness, non-healing sores, etc.)?				
15. Musculoskeletal problems PLEASE CIRCLE (muscle aches, joint pain, swollen joints, Arthritis, Cancer, etc.)?				
16. Psychiatric problems PLEASE CIRCLE (Depression, anxiety, etc.)?				
17. Respiratory problems PLEASE CIRCLE (wheezing, cough, Asthma, Tuberculosis, Bronchitis, etc.)?				
18. Autoimmune diseases PLEASE CIRCLE (Lupus, Crohn's disease, etc.)?				
19. Recent fever for more than 10 days, unexpected weight loss or gain, fatigue?				
20. Other conditions not mentioned above?				
21. If female, are you pregnant or nursing?				
22. Do you drink alcohol?				
23. Do you use illegal drugs?				
24. Do you use tobacco? Yes No What type? How Much? How long?				

Signature of Patient or Legal Guardian **Date**