MEDICAL HISTORY QUESTIONNAIRE

Name Date of Birth Date

Do you have an Advance Directive for Healthcare? ☐ Yes ☐ No

List any **medication** you currently take (Rx and over-the-counter):	Do you have **allergies** to any medications? Yes No If YES, list the medications
SEE ATTACHED MEDICATION LIST	

List any **surgeries** you have had (cataract, appendectomy, etc.):

Do you or your immediate family (blood relatives only—parents, siblings, children, grandparents) have any history of problems in the following areas? If yes, circle all that apply and provide details, including which family member.

	You		Family		
	Yes	**No**	**Yes**	**No**	**Details**
EYES (blurry vision, dry eyes, watery eyes, pain, flashes, floaters, halos, headaches)					
Cataract					
Glaucoma					
Macular Degeneration					
Retina Detachment					
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)					
EARS, NOSE, THROAT (hard of hearing, stuffy nose, seasonal allergies, ear ache, cough, dry mouth, etc.)					
CARDIOVASCULAR (heart attack, high blood pressure, racing pulse, dizziness, etc.)					
RESPIRATORY (congestion, wheezing, short of breath, asthma, bronchitis, emphysema, etc.)					
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)					
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)					
FEMALES Are you pregnant? Nursing?					
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)					
SKIN (pimples, warts, growths, rash, etc.)					
NEUROLOGICAL (numbness, headache, seizures, paralysis, epilepsy, etc.)					
PSYCHIATRIC (anxiety, depression, insomnia)					
ENDOCRINE (diabetes, hypothyroid, etc.)					Diabetes controlled by: ☐ Insulin ☐ Pills ☐ Diet
BLOOD/LYMPH (bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.)					
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)					
OTHER (Cancer, AIDS, HIV+, Hepatitis, etc.)					

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**

Have you ever had a blood transfusion? **YES** **NO** Date of last tetanus shot**:** _____

Do you drink alcohol? **YES NO** How much_____ Do you smoke? **YES** **NO** How much_____ How long _____

Did you ever smoke? **YES NO** How much_____ How many years_____ Year quit_____

FOR OFFICE USE ONLY

Reviewed Date	Tech	Physician		Reviewed Date	Tech	Physician		Reviewed Date	Tech	Physician