

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**

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
1	1997
2	1998
3	1999
4	2000
5	2001
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10	2006
11	2007
12	2008
13	2009
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160	2156

Year quit

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Reviewed Date	Tech	Physician