

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, list the medications:

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

Do you or your immediate family have any problems in the following areas? If YES, please mark the box and circle all that apply and provide additional information.

	You		Family		Details
	Yes	No	Yes	No	
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, etc.)					
ENDOCRINE (diabetes, hypothyroid, etc.)					Diabetes controlled by: <input type="checkbox"/> Insulin <input type="checkbox"/> Medication <input type="checkbox"/> 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? _____