MEDICAL HISTORY QUESTIONNAIRE

Today's Date: ____ / ____ / ____

IMPORTANT: This questionaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____

Birth Date ___ / ___ / ___ Social Security # ____ / ____ / ____ Last Eye Exam ____ / ____ / ____

Medical Information

How is your general health? _____

Do you take medication for any of these systems (Please circle yes or no.)

Gastrointestinal	yes / no	Nervous	yes / no	Endocrine (glands)	yes / no
Ears/Nose/Throat	yes / no	Urinary	yes / no	Blood/Lymph	yes / no
Cardiovascular	yes / no	Muscles/Bones	yes / no	Allergic/Immunologic	yes / no
Respiratory	yes / no	Integumentary (skin)	yes / no	Headaches	yes / no
Mental	yes / no				

Diabetes yes / no **Type** _____ **Date of Diagnosis** _____

Last HGA1C level _____ and / or Daily test levels _____

High Blood Pressure yes / no **Date your blood pressure was last checked:** ____ / ____ / ____

Last blood pressure results _____

Allergies to medication yes / no Medication _____ Reactions _____

Other health problems _____

_____

Have you had any operations? yes / no Kind? _____ When? _____

_____

Name of family doctor and/or primary care physician _____

Date of last visit with primary care physician ____ / ____ / ____

Family Medical History

High blood pressure	yes / no	Relation _____	Macular degeneration	yes / no	Relation _____
Diabetes	yes / no	Relation _____	Retinal detachment	yes / no	Relation _____
Glaucoma	yes / no	Relation _____	Cataracts	yes / no	Relation _____

Social History

Do you use tobacco products? yes / no Drink alcohol? yes/ no

Personal Eye Information

Do you have any eye conditions or problems ? yes / no What kind? _____

Have you had any eye operations? yes / no Type _____ Date ____ / ____ / ____

Have you had an eye injury? yes / no Kind _____ Date ____ / ____ / ____

Do you have glaucoma? yes / no Cataracts? yes / no Dry eyes? yes / no

Macular degeneration? yes / no Retinal detachment? yes / no Blurred vision? yes / no

Do you wear glasses? yes / no Contact lenses? yes / no Type _____

Additional information _____

Doctor Use Only

Reviewed by _____ Date ____ / ____ / ____ Changes yes / no

Reviewed by _____ Date ____ / ____ / ____ Changes yes / no

Reviewed by _____ Date ____ / ____ / ____ Changes yes / no

PLEASE LIST MEDICATIONS ON BACK OF FORM

Medication Record

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am
					pm