

# MEDICAL HISTORY QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Who is your family doctor? \_\_\_\_\_

Do you have any allergies to medications?  YES  NO If yes, please list: \_\_\_\_\_

List ALL medications you are taking: \_\_\_\_\_

Are you now or have you ever taken eye meds on a regular basis? If so, what: \_\_\_\_\_

Have you ever had an injury to the eye? \_\_\_\_\_

List any eye surgeries you have had (cataract, laser, etc.) \_\_\_\_\_

Has an eye care specialist informed you of any problems other than the need for glasses such as cataracts, retinal disease, lazy eye or other eye problems? \_\_\_\_\_

Any family history of eye disease? \_\_\_\_\_

**Do YOU currently have or been diagnosed for any of the following?**

- DIABETES  YES  NO
- High Blood Pressure  YES  NO
- Arthritis  YES  NO
- Cancer  YES  NO
- Heart Disease  YES  NO
- Kidney Disease  YES  NO
- Lupus  YES  NO
- Stroke  YES  NO
- Thyroid Disease  YES  NO
- Sickle Cell Anemia  YES  NO

**Check ALL that apply:**

- Asthma  Emphysema  HIV  Hepatitis
- TB
- Other \_\_\_\_\_

**Is there a family history of any of the following:**

- Diabetes  YES  NO, Whom? \_\_\_\_\_
- High Blood Pressure  YES  NO, Whom? \_\_\_\_\_
- Arthritis  YES  NO, Whom? \_\_\_\_\_
- Cancer  YES  NO, Whom? \_\_\_\_\_
- Heart Disease  YES  NO, Whom? \_\_\_\_\_
- Kidney Disease  YES  NO, Whom? \_\_\_\_\_
- Lupus  YES  NO, Whom? \_\_\_\_\_
- Stroke  YES  NO, Whom? \_\_\_\_\_
- Thyroid Disease  YES  NO, Whom? \_\_\_\_\_
- Sickle Cell Anemia  YES  NO, Whom? \_\_\_\_\_
- Other \_\_\_\_\_  YES  NO, Whom? \_\_\_\_\_

Are you pregnant?  YES  NO \_\_\_\_\_ weeks gestation.

Current Occupation? \_\_\_\_\_ Do you drive? \_\_\_\_\_

Do you wear contact lenses?  YES  NO. If Yes, how long have you worn them? \_\_\_\_\_

Do you drink alcohol?  YES  NO. If yes, how much? \_\_\_\_\_

Do you smoke?  YES  NO. If yes, how much? \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

DOCTOR'S Signature \_\_\_\_\_ Date \_\_\_\_\_