

# Medical History Questionnaire

## Past Medical History

Are you allergic to any medications? No  Yes  If Yes, please list.

Please list all medications you take (including oral contraceptives, aspirin and over the counter medications):

Please list any major surgeries, hospitalizations or injuries you have had in the last year:

## Personal and Family Medical History

Do you or any living or deceased blood relative (parents, grandparents, siblings) have the following conditions?

DISEASE/CONDITION	SELF		FAMILY		RELATIONSHIP TO YOU
	NO	YES	NO	YES	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Social History

Occupation: \_\_\_\_\_

Do you use tobacco products? No  Yes

Do you use recreational drugs? No  Yes

Do you use alcohol? No  Yes

**Eye Surgical History:** Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Procedure: \_\_\_\_\_ Eye: \_\_\_\_\_

## Review of Systems

**Do you have any significant problems in the following areas?**

Ears, Nose, Throat: Sinus trouble, Loss of Balance, etc.

Neurological: Migraines, Bell's Palsy, Shingles, etc.

Respiratory: Asthma, Bronchitis, Emphysema, etc.

Allergic/Immunologic: Allergies, HIV, etc.

Gastrointestinal: Ulcers, Nausea, Abdominal Pain, etc.

Psychiatric: Depression, Drug Dependency, etc.

Genitourinary: Kidneys, Bladder, Ovaries, Prostate, etc.

Constitutional: Fever, Sudden Weight Loss/Gain, etc.

Musculoskeletal: Arthritis, MS, Muscular Dystrophy, etc.

Integumentary: Skin Cancer, Rashes, New Growths, etc.

Hematologic/Lymphatic: Blood Disorders, etc.

Cardiovascular: Blood Pressure, Heart Attack, etc.

Endocrine: Thyroid, Diabetes Type I or II? If yes please note Physician, blood sugar and A1C Value if known.