

MEDICAL HISTORY QUESTIONNAIRE

Name _____ DOB _____ Date _____

Pharmacy _____

Primary Care Doctor _____

List any **medications** you currently take (Rx and over-the-counter) (please use the other side of this form)

Do you have **allergies** to any medications? **YES NO** (please use the other side of this form)

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had: (please use the other side of this form)

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, 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, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease: _____

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**

Do you drink alcohol? **YES NO** If YES, how much? _____ Are you still driving **YES NO**

Do you smoke? **YES NO** If YES, how much? _____ Smoked ___ years

Physician's Signature _____ Date _____

HVF _____ OCT _____

Eye Surgeries: _____

PATIENT MEDICATION SHEET

PATIENT _____ DOB _____ CHART _____

PHYSICIAN _____ PHONE NUMBER _____

MEDICATION NAME:

STARTED

STOPPED

OCULAR MEDICATIONS:

ALLERGIES:

SURGERIES:
