



MEDICAL HEALTH QUESTIONNAIRE

Date: ____/____/____

Name: _____ Primary Dr: _____

Age: _____ Date of Birth: ____/____/____

Reason for Visit: _____

List any medications you currently take (prescription & over-the-counter):

Do you have any allergies to any medications? YES NO If YES, please list the medications:

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

List any surgeries you have had (cataract, appendectomy) _____

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

	Y	N	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, ear ache, cough, dry mouth, etc)			
Cardiovascular (high BP, racing pulse, etc)			
Respiratory (congestion, wheezing, short of breath)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, etc)			
Genital/Kidney/Bladder (painful urination, frequent urination, impotence, jaundice, etc)			
Females – Are you pregnant or nursing?			
Muscles/Bones/Joints (joint pain, stiffness, swelling, cramps, arthritis, etc)			
Skin (pimples, warts, growths, rash, etc)			
Neurological (numbness, headache, seizures, paralysis)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, insomnia)			
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 any of these diseases? (Circle all that apply & indicate family member)

Blindness _____ Macular Degeneration _____ Retinal Detachment _____ Glaucoma _____

Diabetes _____ Hypertension _____ Heart Attack _____ Stroke _____

Arthritis _____ Thyroid Disease _____ Eye That Turns _____ Cancer (Type?) _____

Wear a Patch Over Eye When Younger? _____

Social History

Does your vision limit any activities of daily living (driving, reading, sports, work etc?) YES NO

Have you ever been exposed to HIV or Hepatitis? YES NO

Do you drink alcohol? YES NO If YES, how much? _____

Do you smoke? YES NO If YES, how much? _____

Doctor / Staff Signature: _____ Date: ____/____/____