MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date_____

Date of birth_____ Date of last eye exam _____

Reason for today's visit_____

Medical doctor's name _____

Medical doctor's address and phone number_____

Pharmacy you use and phone number_____

List past surgeries:_____

_____

Allergies to medications:_____

List past major illnesses:_____

List ***current*** problems. If yes provide explanation, if no please mark no.

Disease	**Yes**	**No**	**Explanation**
Eyes			
Loss of vision			
Blurred vision			
Loss of side vision			
Eye pain			
Any other			
General			
Fever			
Weight Loss			
Others			
Ears/Nose/Throat			
Cardiovascular/High B.P.			
Respiratory			
Gastrointestinal			
Genital, Kidney, Bladder			
Muscles, Bones, Joints			
Neurological/Stroke			
Psychiatric			
Endocrine / Diabetes			
Others			

Family medical history:_____

_____

Ht._____ Wt._____

Social History

Current occupation_____Marital status_____

Do you smoke?_____ If yes how much?_____

Do you drink alcohol? _____How much?_____

History reviewed_____ Doctor's signature_____