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: _____
_____

Height: _____ Weight: _____

Social History:
Current occupation: _____ Marital status: _____
Do you smoke? _____ If yes, how much? _____
Do you drink alcohol? _____ If yes, how much? _____