

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 _____