Medical History Questionnaire

Name ____ Today's Date _________________________________
Birth Date ___________________________ Current Medical Doctor ________________________
Last Medical Exam ________________________
List any allergies or medicines or other substances: ____
List any medications you are taking (prescription or otherwise):
____
List any recent hospitalizations or surgeries: ____
Review of Systems: Do you currently, or have you ever had any problems in the following areas:

System:	Yes	No
EYES		
Loss of vision	_____	_____
Blurred vision	_____	_____
Double vision	_____	_____
Redness	_____	_____
Burning	_____	_____
Itching	_____	_____
Light Sensitivity	_____	_____
Tearing/Watery Eyes	_____	_____
Eye Injury	_____	_____
Eye Surgery	_____	_____
Floater/Flashers	_____	_____
Glare/Halos	_____	_____
Crossed or Lazy Eye	_____	_____
Cataracts	_____	_____
Glaucoma	_____	_____
Eye Pain/Soreness	_____	_____
Retinal Disease	_____	_____
ENDOCRINE		
Thyroid	_____	_____
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	_____	_____
Joint/Back Pain	_____	_____

System	Yes	No
VASCULAR/HEART		
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
NEUROLOGICAL		
Headaches	______	_____
Migraines	______	_____
Seizures	______	_____
RESPIRATORY		
Asthma	______	______
COPD/Emphysema	______	______
SKIN DISORDER	______	______
PSYCHIATRIC	______	______
IBS/ CHRON'S	______	______
EAR/NOSE/THROAT/MOUTH		
Allergies/Hay Fever	______	______
GENITOURINARY		
Kidney/Bladder	______	______
Genital	______	______
SLEEPING DISORDER		
Sleep Apnea	______	______
HEMATOLOGIC		
Anemia	______	______

HAVE YOU HAD CANCER: YES or NO Type ______________________
PREGNANT/NURSING YES or NO
Social History:
Do you drink alcohol? YES or NO HOW MUCH? ________________ Do you use illegal drugs? YES or NO
Do you use tobacco products? YES or NO HOW MUCH? ___________
Have you ever been exposed to or infected with: (circle) Gonorrhea Hepatitis HIV Syphilis Other NO TO ALL

Family History:
Please note any family history (parents, siblings, children) for the following conditions:

OCULAR	YES	NO	WHO
Blindness	_____	_____	____________
Glaucoma	_____	_____	____________
Macular Degeneration	_____	_____	____________
Retinal Detachment	_____	_____	_____________
Crossed Eyes	_____	_____	_____________

SYSTEMIC	YES	NO	WHO
Diabetes	_____	______	_____________
High Blood Pressure	_____	______	_____________
Cancer	_____	______	_____________
Heart Disease	_____	______	_____________

REVIEWED BY (DOCTOR SIGNATURE) ____, OD

By signing this form, I consent to treatment for myself and/or on behalf of the minor to whom this information pertains. I give permission for the doctor to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of Minor and have the authority to authorize care and treatment.

PARENT/GUARDIAN(signature)____Date_____________