

# MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

Last Eye Exam \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

**REVIEW OF SYSTEMS - PLEASE ANSWER ALL QUESTIONS**

Do you have or have you had any problems in the following areas?

IF "YES", please provide information.

**YES NO**

**CONSTITUTIONAL SYMPTOMS**

[ ] [ ] Weight Loss \_\_\_\_\_

**EYES**

[ ] [ ] Change in Vision \_\_\_\_\_

[ ] [ ] Redness \_\_\_\_\_

[ ] [ ] Sandy or gritty feeling \_\_\_\_\_

[ ] [ ] Itching, Burning, Tearing \_\_\_\_\_

[ ] [ ] Difficulty reading \_\_\_\_\_

[ ] [ ] Eye Pain \_\_\_\_\_

[ ] [ ] Difficulty night driving \_\_\_\_\_

[ ] [ ] Floaters \_\_\_\_\_

**EAR, NOSE, MOUTH, THROAT**

[ ] [ ] Dry throat/mouth \_\_\_\_\_

**CARDIOVASCULAR**

[ ] [ ] High Blood Pressure \_\_\_\_\_

[ ] [ ] Heart attack \_\_\_\_\_

[ ] [ ] Chest pain \_\_\_\_\_

**RESPIRATORY**

[ ] [ ] Asthma/Emphysema \_\_\_\_\_

[ ] [ ] Tuberculosis/Positive TB test \_\_\_\_\_

**GASTROINTESTINAL**

[ ] [ ] Colitis \_\_\_\_\_

[ ] [ ] Hepatitis \_\_\_\_\_

**GENITOURINARY**

[ ] [ ] Kidney disease \_\_\_\_\_

**MUSCULOSKELETAL**

[ ] [ ] Rheumatoid Arthritis \_\_\_\_\_

[ ] [ ] Joint pain \_\_\_\_\_

**NEUROLOGICAL**

[ ] [ ] Headache \_\_\_\_\_

[ ] [ ] Seizures \_\_\_\_\_

[ ] [ ] Stroke \_\_\_\_\_

**YES NO**

**ENDOCRINE**

[ ] [ ] Diabetes \_\_\_\_\_

[ ] [ ] Thyroid \_\_\_\_\_

**HEMATOLOGICAL**

[ ] [ ] Blood transfusions \_\_\_\_\_

[ ] [ ] Sickle Cell \_\_\_\_\_

**ALLERGIC AND IMMUNOLOGIC**

[ ] [ ] Seasonal allergies \_\_\_\_\_

[ ] [ ] AIDS \_\_\_\_\_

**FAMILY HISTORY** (if yes, indicate your relationship)

[ ] [ ] Blindness \_\_\_\_\_

[ ] [ ] Cataract \_\_\_\_\_

[ ] [ ] Glaucoma \_\_\_\_\_

[ ] [ ] Macular degeneration \_\_\_\_\_

[ ] [ ] Retinal detachment \_\_\_\_\_

[ ] [ ] Diabetes \_\_\_\_\_

[ ] [ ] Stroke \_\_\_\_\_

[ ] [ ] Other \_\_\_\_\_

**SOCIAL HISTORY**

[ ] [ ] Do you smoke? Packs per day \_\_\_\_\_

[ ] [ ] Do you drink alcohol? How much? \_\_\_\_\_

[ ] [ ] Do you drive? \_\_\_\_\_

Reviewed	Date	By	Dr.
200__			
200__			
200__			
200__			
200__			