Medical History Questionnaire

Patient Name:_____Nickname:_____Date:_____

Date of Birth:_____ Sex:_____ Gender:_____ Marital Status:_____Race:_____

Street Address:_____City:_____Zip:_____

Phone Number:_____Email address:_____

Primary Care Physician:_____Last Eye Exam:_____

Insurance:_____ Employer:_____

Preferred Language:_____ How did you hear about us?_____

Review of Systems

Please List medications you are taking including eye drops 1. 4. 2. 5. 3. 6.		
Do any of these conditions apply to you?(circle or list to the side)		
Allergies/Immunologic: seasonal allergies, rheumatoid arthritis, lupus	Yes or No	
Cardiovascular: Hypertension, Stroke, high cholesterol, heart disease	Yes or No	
Constitutional: Developmental disabilities, cancer	Yes or No	
Ear/Nose/Throat: Hearing loss, sinusitis, dry mouth	Yes or No	
Endocrine: Thyroid problems, diabetes	Yes or No	
Gastrointestinal: Crohn's, ulcer, acid reflux	Yes or No	
Genitourinary: kidney disease, pregnant/nursing	Yes or No	
Hematological/Lymphatic: anemia, leukemia	Yes or No	
Integumentary: eczema, rosacea	Yes or No	
Musculoskeletal: arthritis, osteoarthritis, fibromyalgia,	Yes or No	
Neurological: Multiple Sclerosis, cerebral palsy, migraine, tumor	Yes or No	
Psychiatric: depression, anxiety, attention deficit, bipolar	Yes or No	
Respiratory: asthma, bronchitis, emphysema, COPD	Yes or No	
Do you have any allergies to medication?	Yes or No	
Eyes: glaucoma, cataracts, crossed eyes, retina problems, flashes/floaters, other(please specify	Yes or No	

Family History (Do any of these conditions run in your immediate family?) Please circle family member below

- ☐ Cancer: Grandmother Grandfather Father Mother Brother Sister Son Daughter
- ☐ Diabetes: Grandmother Grandfather Father Mother Brother Sister Son Daughter
- ☐ High Blood Pressure: Grandmother Grandfather Father Mother Brother Sister Son Daughter
- ☐ Glaucoma: Grandmother Grandfather Father Mother Brother Sister Son Daughter
- ☐ Macular Degeneration: Grandmother Grandfather Father Mother Brother Sister Son Daughter
- ☐ Other_____

Do you drink alcohol? ☐ Yes ☐ No If yes, How much?_____

Do you smoke? ☐ Yes ☐ No If yes, How much?_____

Height:_____ Weight_____