MEDICAL HISTORY QUESTIONNAIRE

Name _____Date ____/____/____ Family Physician: _____

Do you *currently* have any problems in the following areas? If "YES", provide information:

System	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (Fever, Weight loss, Other)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
SKELETAL (Osteoporosis, arthritis)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL/PSYCHIATRIC (Anxiety, depression)			
BLOOD (Cholesterol, anemia, lupus, etc.)			

PAST EYE HISTORY AND RELATED SYSTEMIC CONDITIONS

Have you EVER been diagnosed with the following conditions? If "YES" indicate when diagnosed and treated.

Condition	YES	NO	Date Diagnosed & description of treatment
Age Related Macular Degeneration			
Glaucoma			
Cataracts			
Eye Injury			
Eye Surgeries			
Diabetes			
High Blood Pressure			
Cancer			
Stroke			
Arthritis			
Retinal Disease/Retinal Detachment			
Corneal Disease			

FAMILY HISTORY

Disease	YES	NO	Relationship to Patient
Blindness			
Macular Degeneration			
Glaucoma			
Cataracts			
Diabetes			
Cancer			
Other			

SOCIAL HISTORY

Do you smoke? ☐Yes ☐ No

If yes-How many packs per day? ___

Are you pregnant? ☐Yes ☐ No

Reviewed	Patient Initials
____/____/____	_____
____/____/____	_____
____/____/____	_____

_____ ____/____/____

Patient's Signature Date