

# MEDICAL HISTORY QUESTIONNAIRE

NAME

BIRTH DATE

CHART #

## PAST MEDICAL HISTORY/REVIEW OF SYSTEMS

	YES	NO	COMMENTS
DIABETES WHO IS YOUR DIABETES DOCTOR?			HOW LONG?
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
CANCER			
EAR, NOSE(SINUS) OR THROAT DISEASE			
LUNG DISEASE			
HEART DISEASE			
STOMACH / INTESTINAL DISEASE			
KIDNEY DISEASE			
STROKE / SEIZURES			
HIV / SEXUALLY TRANSMITTED DISEASE/HEPATITIS			
HEADACHES / MIGRAINES			
THYROID DISEASE			
ARTHRITIS / RHEUMATOID / OSTEOPOROSIS			
DEPRESSION / ANXIETY			
HAVE YOU HAD ANY UNEXPLAINED FEVER / WEIGHT LOSS			
DO YOU TAKE ANY MEDICATIONS?			
ARE YOU ALLERGIC TO ANY MEDICATIONS?			
DO YOU HAVE ANY OTHER ILLNESSES?			
HAVE YOU EVER HAD SURGERY FOR ANY REASON?			comments:
List surgery:			

## PAST EYE HISTORY

## OFFICE USE ONLY

	YES	NO	DATE	TECH	DOCTOR
CATARACTS					
GLAUCOMA					
RETINAL DETACHMENT					
MACULAR DEGENERATION					
CROSSED EYES					
EYE TRAUMA / INJURY					
ANY EYE SURGERY OR LASER TREATMENT?					
OTHER					

## FAMILY HISTORY

BLINDNESS					
GLAUCOMA					
RETINAL DETACHMENT					
MACULAR DEGENERATION					

## SOCIAL HISTORY

DO YOU LIVE ALONE?					
DO YOU DRIVE?					
DO YOU HAVE VISUAL DIFFICULTIES WHEN DRIVING?					
DO YOU HAVE PROBLEMS WITH NIGHT VISION?					
DO YOU SMOKE?					
DO YOU DRINK ALCOHOL?					