MEDICAL HISTORY QUESTONNAIRE

Name: _____ DOB: _____ Account #: _____

FAMILY HISTORY (Immediate family members, please fill in relationship)

Glaucoma _____
Cataracts _____
Blindness/Loss of Vision _____
Macular Degeneration _____
Retinal Detachment _____
Diabetes _____
High Blood Pressure _____
High Cholesterol _____

PERSONAL HISTORY

Family Physician: _____Clinic: _____Date of last exam: _____

Please list all prescription and over-the-counter medications you take. Include frequency and dosage:

_____

_____

Please list all prescription and over-the-counter medications you are allergic to:

_____

Have you had any major surgeries? Please list type of surgery with date:

_____

Do you use cigarettes/tobacco? Never Used Current User Former User
Do you consume alcohol? YES NO If yes: Occasionally Socially Daily
Do you use any other substances? YES NO
How many hours do you spend looking at a computer, tablet, or cell phone per day?
Less than 1 hour 1-3 hours 3-6 hours 6-10 hours 10+ hours

HAVE YOU BEEN DIAGNOSED WITH, TREATED FOR, OR EXPERIENCE ANY OF THE FOLLOWING? Check all that apply

EYES
□ Previous Surgery
□ Wear Contact Lenses
□ Pain
□ Double Vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Dry Eyes
□ Flashes
□ Floaters
□ Blurred Vision

EAR, NOSE, & THROAT
□ Hard of Hearing
□ Ringing in Ears
□ Vertigo
□ Allergies
□ Hay Fever

CARDIOVASCULAR
□ Chest Pain
□ Dizziness
□ Fainting Spells
□ Shortness of Breath
□ Irregular Heart Beat
□ Difficulty Lying Flat
□ High Blood Pressure
□ Vascular Disease

CONSTITUTIONAL
□ Fatigue/Weakness
□ Fever
□ Weight Gain
□ Weight Loss

RESPIRATORY
□ Cough
□ Congestion
□ Wheezing
□ Asthma
□ Chronic Bronchitis
□ Emphysema

GASTROINTESTINAL
□ Heartburn
□ Nausea/Vomiting
□ Jaundice/Hepatitis

GENITO-URINARY
□ Pain/Difficulty Urinating
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

PSYCHIATRIC
□ Anxiety/Depression
□ Mood Swings
□ Difficulty Sleeping

MEDICAL HISTORY QUESTONNAIRE

ENDOCRINE
□ Increased Thirst
□ Increased Hunger
□ Increased Urination
□ Increased Sweating
□ Fingernail Changes
□ Type 1 Diabetes
□ Type 2 Diabetes

BLOOD/LYMPHNODES
□ Bruise Easily
□ Gums Bleed Easily
□ Prolonged Bleeding
□ Heavy Aspirin Use
□ Anemia

MUSCULOSKELETAL
□ Stiffness
□ Arthritis
□ Joint Pain/Swelling

SKIN
□ Rash/Sores
□ Lesions
□ Hives/Eczema

NEUROLOGICAL
□ Seizures
□ Weakness/Paralysis
□ Numbness
□ Tremors
□ Headaches
□ Migraines

IMMUNOLOGIC
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure