MEDICAL HISTORY QUESTIONNAIRE

This form is to be filled out annually

Name: _____ Date: _____/_____/_____
Date of Birth: ____/____/_____ Height: _____ Weight: _____
Please list ALL medications you are taking; including over-the-counter:_____
_____

List any and all allergies: _____

Please circle any problems you <u>currently</u> have:

VISION:	Dryness	Pain	Redness	Cataracts
Distorted Vision	Lazy Eye	Glare	Infection	Glaucoma
Drooping Eyelids	Tired Eyes	Tearing	Vision Loss	Redness
Mucous Discharge	See Double	Itching	Burning Sensation	Sandy Feeling
Blurry Vision	Macular Degeneration			

GENERAL/CONSTITUTIONAL: Fever Weight Loss Other: _____
EARS, NOSE, THROAT: Chronic Cough Dry Mouth Ear infection Sinus Infection
CARDIOVASCULAR: Heart Blood Vessels High / Low Blood Pressure
RESPITORY: Asthma Emphysema Other: _____
GASTROINTESTINAL: Intestinal Disease Stomach Ulcers Other: _____
GENITAL, KIDNEY, BLADDER: What? _____
MUSLCES, BONES, JOINTS: What? _____
SKIN: Acne Skin Cancer Warts
NEUROLOGICAL: Multiple Sclerosis Other: _____
PSYCHIATRIC: Anxiety Depression Other: _____
ENDOCRINE: Diabetes: HbAic _____% Hypothyroid Hyperthyroid
BLOOD/LYMPH: Anemia Cholesterolemia Other: _____
ALLERGIC/IMMUNOLOGIC: Aids Seasonal Lupus Sjorgrens Arthritis

PERSONAL SOCIAL HISTORY

Please circle where needed

Current Occupation: _____
Marital Status: Divorced Married Single Widowed Significant Other
Do you live alone? YES NO Do you Drive? YES NO Glare at night? YES NO
Do you wear contacts? YES NO If so, how long have you worn contacts? _____
What brand do you wear? _____ How many days/months do you wear them? _____
Can you wear them all day with comfort? YES NO Would you consider a change? YES NO
Do you currently use the pill or patch for birth control? YES NO
Do you have a current (2 years old or less) pair of glasses? YES NO
Do you drink alcohol? YES NO How much / How often? _____
Do you smoke? YES NO How much / How often? _____
How did you hear about our office? Friend Insurance Internet Family member
Other: _____

FAMILY HISTORY

Please circle the problems you know your blood relatives (Grandparents, Parents, Siblings) have had:

High/Low Blood Pressure	Arthritis	Cataracts	Lupus	Cancer
Hypo/Hyper Thyroid	Blindness	Diabetes	Stroke	Glaucoma
Macular Degeneration	Heart Disease	Other: _____		