Medical History Questionnaire

Patient Name: ____ Date of Birth: _______________

Address: ____ City/ZIP: ___________________

Phone: _________________________ Email: ____

Last Eye Exam: ____________ By Whom (if Walmart, which location?): ______________________________

Review of Systems

Please list medications you are taking including eye drops (if none, please check box below)

☐ I do not currently take any medication

1.	4.
2.	5.
3.	6.

Do any of these conditions apply to you? (If yes, circle condition below or list in empty column on right)

□ No □ Yes	**Constitutional**: developmental disabilities, cancer	
□ No □ Yes	**Ear/Nose/Throat**: hearing loss, sinusitis, dry mouth	
□ No □ Yes	**Neurological**: multiple sclerosis, cerebral palsy, migraine, tumor	
□ No □ Yes	**Psychiatric**: depression, anxiety, attention deficit, bipolar	
□ No □ Yes	**Cardiovascular**: hypertension, stroke/CVA, heart disease, vascular disease, congestive heart failure	
□ No □ Yes	**Respiratory**: asthma, bronchitis, emphysema, chronic obstruction, sleep apnea	
□ No □ Yes	**Gastrointestinal**: Chrohn's, ulcer, acid reflux	
□ No □ Yes	**Genitourinary**: kidney disease, pregnant/nursing	
□ No □ Yes	**Musculoskeletal**: arthritis, osteoarthritis, fibromyalgia, osteoporosis	
□ No □ Yes	**Integumentary**: eczema, rosacea	
□ No □ Yes	**Endocrine**: thyroid problems, diabetes	
□ No □ Yes	**Hematological/Lymphatic**: Anemia, high cholesterol	
□ No □ Yes	**Allergies/Immunologic**: seasonal allergies, rheumatoid arthritis, lupus	
□ No □ Yes	**Drug Allergies**: Penicillin, Sulfa, Codeine, other	
□ No □ Yes	**Eyes**: Glaucoma, cataracts, macular degeneration, strabismus, retinal disease, other (please specify)	

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

□	Cancer:	Grandparent	Father	Mother	Brother	Sister	Son	Daughter
□	Diabetes:	Grandparent	Father	Mother	Brother	Sister	Son	Daughter
□	High Blood Pressure:	Grandparent	Father	Mother	Brother	Sister	Son	Daughter
□	Macular Degeneration:	Grandparent	Father	Mother	Brother	Sister	Son	Daughter
□	Glaucoma:	Grandparent	Father	Mother	Brother	Sister	Son	Daughter

□ Other (specify relationship) _____________________________________

Do you smoke? □ No □ Yes If yes, how much? □ ½ Pack/day □ Pack/day □ Other _____________

Do you drink alcohol? □ No □ Yes If yes, how much? □ Social □ 1 or less daily □ Other _____________

Doctor Signature: ____ Date: ____________