Medical History Questionnaire

(Must be updated at each visit)

Please answer all questions.

Last Name _____ First Name _____ MI _____

Address _____

Telephone (W)_____ (H) _____

SSN _____ - _____ - _____ Date of Birth_____

Occupation _____

Employer _____

Emergency Contact/Telephone Number _____

Date of last eye exam _____ Dilated?_____ Today's date _____

Medical Information

What is your general health?_____

Do you have problems with any of these systems? (please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
				Allergic/immunologic	Y/N

Please explain _____

Diabetes Y/N Type _____ Date of diagnosis _____

Allergies Y/N Type _____ What happens?_____

Medication allergy Y/N What happens? _____ Headaches Y/N

Other health problems _____

Current medications(s)_____

Have you had any operations? Y/N Kind? _____ When?_____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

Family History

High blood pressure	Y/N	Relation _____	Macular degeneration	Y/N	Relation _____
Diabetes	Y/N	Relation _____	Retinal detachment	Y/N	Relation _____
Glaucoma	Y/N	Relation _____	Cataracts	Y/N	Relation _____
Other eye condition(s)	Y/N	What kind?_____			Relation _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____

Have you had an eye injury? Y/N Kind_____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N

Other eye problems? Y/N What kind? _____

Do you wear glasses? Y/N Contact lenses? Y/N Type _____

Additional information _____

Whom may we thank for referring you? _____

Doctor's initials _____