OFFICE USE ONLY
NP PP GLX CLX DM

MEDICAL HISTORY QUESTIONNAIRE

Full Name: _____Birth Date: _____Today's Date: _____

Address: _____ City: _____ Zip Code: _____

Phone Number: _____ [ ] Cell [ ] Home Email address: _____

Race (please circle): Caucasian African-American Asian Hispanic Pacific-Islander Multi-racial Other

Name of your Primary Care Physcian: _____ Clinic/City: _____

Current **medications patient uses** (prescription meds, insulin, over-the-counter & vitamins)

_____ _____ _____ _____

_____ _____ _____ _____

Any allergies to medications? **YES NO** If yes, list which ones: _____

List any **EYE** related diseases, injuries or surgeries:

_____

Are you a contact lens wearer? **YES NO** If no, are you interested in trying them? **YES NO**

How did you hear about our office? Friend: (enter name) _____ TV ___ Mailing ___ Internet ___

YOUR MEDICAL HISTORY

	Yes	No
Here for annual exam		
Diabetic		
Blurred vision		
Frequent Headaches		
Failed vision screening at DMV		
Flashers/Floaters		
Glare at night		
Dry Eye		
Watery Eye		
Itching		
Pain or Redness		
Do you smoke?		
Cataracts		

FAMILY HISTORY

Family members with any of the following:
(Parents, Siblings, Grandparents)

	Yes	No	Who?
Cataracts			
Glaucoma			
Macular Degeneration			
Diabetes			
Heart Disease			
Cancer			
Blindness			

REVIEW OF SYSTEMS – Please check all that apply.

Allergic: ___ environmental ___ animals ___ food ___ rheumatoid arthritis ___ lupus

Ears, Nose, Mouth & Throat: ___ upper respiratory tract infection ___ ear ache ___ sore throat

Constitutional: ___ developmental disability ___ weight loss___ fever ___ fatigue ___ trauma

Cardiovascular: ___ heart disease ___ hypertension (HBP) ___ stroke ___ vascular disease

Gastrointestinal: ___ Crohn's ___ colitis ___ ulcer ___ digestive

Eyes: ___ glaucoma ___ cataracts ___ macular degeneration ___ surgery

Neurological: ___ multiple sclerosis ___ epilepsy

Musculoskeletal: ___ fibromyalgia___ muscular dystrophy ___ osteoarthritis___ ankylosing spondylitis

Respiratory: ___ smoker ___ asthma ___ bronchitis ___ emphysema

Endocrine: ___ non-insulin diabetes ___ insulin w/ diabetes ___ thyroid dysfunction ___ hormonal dysfunction ___ high cholesterol

None:_____