



Patient Medical History Questionnaire

Name: _____ Date Today: ____/____/____

Age: _____ Date of Birth: ____/____/____ Gender: Male ____ Female ____ Weight: _____ Height: _____

Review of Systems: Please check any of the following health problems which you have or have had:

Cardiovascular

- Heart disease
- Heart attack/chest pain
- High blood pressure
- Stroke
- Congestive Heart Failure
- Heart valve problems

Respiratory

- Lung Disease
- Tuberculosis
- Sleep Apnea

Hematologic/Lymphatic

- Anemia
- Bleed/bruise easily

____ Other (please list):

____ Cancer (please list):

Endocrine

- Diabetes
- Thyroid disease

Gastrointestinal

- Ulcers
- Colitis/diverticulitis
- Liver disease/hepatitis

Musculoskeletal/Skin

- Arthritis
- Joint replacement

____ No Medical Problems

Ear/Nose/Throat

- Sinus disease

Genitourinary

- Kidney problems
- Bladder problems
- Prostate problems

Neurologic/Psychiatric

- Seizures/convulsions
- Alzheimer's
- Parkinson's disease
- Mental health problem

Immune/Allergic

- Immune deficiency
- Environmental allergy

Past Medical History: (Please list any surgery, injuries, operations or hospitalizations *other than eyes*)

Medications: (Please list all medications that you are currently taking with the strength and how often, *including eyedrops, over the counter medications and nutritional supplements*)

Allergies: (Please list any allergies to any medications or medical tests)

Name: _____ Date Today: ____/____/____

Primary Medical Physician: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other physicians involved in your care: _____

Previous Eye Care: _____

Social History: (Please include how long) Smoking _____ Alcohol _____ Other _____

Individuals living in your household: _____ Pets: _____

Occupation: _____ Hobbies: _____

Family History: (Please indicate any diseases that run in your family and who had the disease)

- | | | |
|------------------------|-----------------------------|--------------------------|
| ___ Cancer | ___ Diabetes | ___ Hypertension |
| ___ Heart disease | ___ Arthritis | ___ Neurologic disorder |
| ___ Thyroid disease | ___ Other medical problems: | |
| ___ Retinal detachment | ___ Glaucoma | ___ Macular degeneration |
| ___ Cataracts | ___ Other eye disorders: | |

Eye History: Have you ever been diagnosed with:

- | | | | |
|--------------------------|--------------------------|-------------------------|-----------------------|
| ___ Cataracts | ___ Macular degeneration | ___ Glaucoma | ___ Retinal disorders |
| ___ Diabetic retinopathy | ___ Corneal problems | ___ Other eye problems: | |

Eye Surgery/Eye Trauma: (Please list what and when)

Right Eye: _____

Left Eye: _____

Where did you get your last pair of glasses/contact lenses? _____ When? _____

Contact lens wearers: Type of lens: _____ How long worn? _____ Replaced how often? _____
How long do you usually wear them each day? _____ Do you ever wear them overnight? _____ If so, how often? _____
Cleaning/Soaking system _____ Does water ever come in contact with your lenses? _____

Present eye problems or concerns you have: _____

