Medical History Questionnaire

Date:	
Name: Last First MI	Home Phone:
	Work Phone:
Address:	CellPhone:
City: State: Zip:	E-mail:
Birth date: Social Security:	**Preferred Communication**: Circle
Height: Weight:	Home Work Cell
Gender: Male Female	E-Mail US Mail
Married: Yes No Spouse's Name:	**Primary Language:** English Other
Account Responsible:	**Race**: White Other
Address if different from above:	**Ethnicity:**
	Unknown Nonhispanic/Latio
Medical Doctor: Location:	Hispanic/Latino
Last Medical Exam: Reason:	

Insurance information

Insurance: Insured DOB:	Employer:

Patient Review of Systems:

	Yes	**NO**	**Explain:**
Constitution (fever, fatigue, sudden weight gain/loss)			
Cardiovascular (heart disease, high blood pressure, stroke)			
Ears, Nose, Mouth, Throat			
Respiratory (copd,emphysema, asthma)			
Gastrointestinal			
Musculoskeletal (arthritis, muscle pain)			
Integumentary (skin conditions)			
Neurological (headaches, migraines)			
Psychiatric (depression, anxiety)			
Endocrine (diabetes, thyroid)			
Hematologic/Lymphatic (anemia)			
Allergic/Immunologic (allergies, hayfever)			
Other			
Pregnant / Nursing Due Date:			
Do you work on a computer? If so, Hours per day			

List all major surgeries and/or hospitalizations you had

Procedure:	*Surgeon :*	*Date:*

Last Eye Exam: Location:

Patient Present/Past Eye History	Yes	No
Glaucoma		
Cataracts		
ARMD-macular degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus-crossed eye (s)		
Amblyopia-lazy eye (s)		
Diabetes		
Dry Eye		
Do you wear glasses?		
Do you wear contacts?		
Flashes/Floaters		
Other		

Family History	Relationship
	parents, siblings
	grandparents Maternal/Paternal
Glaucoma	
Cataracts	
Macular Degeneration	
Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus-crossed eye	
Amblyopia-lazy eye	
Diabetes	
Cancer	
Heart Disease/HBP	
Arthritis	
Other	

Social History	Yes	NO	yes, type/amount/length
Tobacco			
Drugs			
Alcohol			
Other			
Hobbies			

Are you allergic to medications?		
If Yes Please List	Yes	No

Medications:Please list or provide copy

Tobacco Status

			Current every day smoker
			Current same day smoker
			Smoker
			Former smoker
			Never a smoker
			Current status unknown
			Unknown if ever smoked