MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:**_____

Sex: M / F Current Height: _____ Current Weight: _____

Primary Care Physician: _____Specialty Physician:_____

CONDITIONS:	**Circle any and all conditions that apply to you or check none.**	**NONE**
GENERAL/CONSTITUTION:	fatigue, insomnia, headaches, change in appetite, chills, fever, weight loss, weight gain, mood swings, history of MRSA infection	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, high cholesterol, pace maker, irregular heartbeat, mitral valve prolapse, stents	
EARS, NOSE, THROAT:	hard of hearing, ear ache, chronic cough, dry mouth, sinus/allergy	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure, cough, sleep apnea	
GASTROINTESTINAL:	heartburn, indigestion, diarrhea, constipation, irritable bowel syndrome, hepatitis, hernia, ulcers, nausea, GERD, abdominal pain	
GENITOURINARY:	bladder problems, painful urination, kidney stones, blood in urine, prostate problems, kidney failure	
FEMALES:	Are you pregnant? Are you nursing? Ovarian problems	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis, gout,	
INTEGUMENTARY	rashes, eczema, psoriasis, bumps or lumps	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, TIA, dementia, memory loss, Alzheimer's, Parkinson's, Bell's Palsy, cerebral palsy	
PSYCHIATRIC:	anxiety, depression, bi-polar, agitated, panic attacks	
ENDOCRINE:	diabetes, last A1C_____, hypothyroid, hyperthyroid, hormone, increased thirst, hypoglycemia, Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	anemia, bleeding disorder, blood clots, vitamin B12 deficiency, leukemia, lymphoma	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome	
CANCER:	breast, prostate, lung, skin, colon , other _____	
EYE HISTORY:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, dry eye, macular degeneration, droopy eyelid	
EYES:	Do you wear glasses? Do you wear contact lenses?	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

_____

Have you ever been hospitalized? Yes No

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Brother Sister Grandma (pa)	Heart Disease	yes	no	Mother Father Brother Sister Grandma (pa)
Macular Degeneration	yes	no	Mother Father Brother Sister Grandma (pa)	Hypertension	yes	no	Mother Father Brother Sister Grandma (pa)
Blindness	yes	no	Mother Father Brother Sister Grandma (pa)	Stroke	yes	no	Mother Father Brother Sister Grandma (pa)
Retinal Disorders	yes	no	Mother Father Brother Sister Grandma (pa)	Thyroid Disease	yes	no	Mother Father Brother Sister Grandma (pa)
Cataracts	yes	no	Mother Father Brother Sister Grandma (pa)	Arthritis	yes	no	Mother Father Brother Sister Grandma (pa)
Glaucoma	yes	no	Mother Father Brother Sister Grandma (pa)	Cancer	yes	no	Mother Father Brother Sister Grandma (pa)
Diabetes	yes	no	Mother Father Brother Sister Grandma (pa)	Type of Cancer: _____			Mother Father Brother Sister Grandma (pa)

PLEASE COMPLETE BOTH SIDES OF FORM. THANK YOU.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:______________________________Date of Birth:______________Date:_____________

If new to our office, how did you hear about our practice?

(Circle one): Family/Friend OD/PCP Website Yellow Pages Web Search Other__________

Date of last flu shot:____________________ Date of last pneumonia vaccine:____________________

SOCIAL HISTORY:

(Circle:) Student Homemaker Employed Retired **(Circle:)** Single Married Separated Divorced Widowed

Do you currently or have you ever use(d) Tobacco? Yes / No If no longer using, year quit ____________

Cigarettes / Smokeless _____ # Packs/Times a Day ______# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other ____________

Substance Abuse? Yes / No Rarely Daily Weekly ____

Street Drugs? Yes / No Medical Marijuana? Yes / No

LIST ALL DRUG ALLERGIES, if none state none____

____

List all Prescriptions and Over the Counter medications you are currently taking (including Eye Drops). If you have a list please give to the receptionist to copy in lieu of filling out the form:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			

PLEASE COMPLETE BOTH SIDES OF FORM. THANK YOU.