MEDICAL HISTORY QUESTIONNAIRE

Are you currently taking any **medications** (Rx and over-the-counter)? _____yes_____no. If yes, list the medications:_____

_____

_____

_____

Do you have **allergies** to any medication? **YES** **NO**

If YES, list the medications: _____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	PLEASE EXPLAIN
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that **apply)?** **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**

Have you ever had a blood transfusion? **YES** **NO**

Do you drink alcohol? **YES** **NO** If YES, how much?_____

Do you smoke? **YES** **NO** If YES, how much?_____ How many years? _____

Primary Physician _____ *Endocrinologist* _____