Medical History Questionnaire

Patient Name:	DOB:	Date:
Do you wear glasses? ☐ Yes ☐ No	Do you wear contacts? ☐ Yes ☐ No	
What is your occupation?	Who is your family physician?	

Do you currently experience problems in the following areas? ***If yes, please provide more information.***	
System	**Comments**
General Health/Constitution	☐ Pregnant ☐ Cancer
Cardiovascular	☐ Heart Disease ☐ High Cholesterol ☐ High Blood Pressure ☐ Stroke
Respiratory (breathing)	☐ Asthma ☐ Emphysema ☐ Chronic Obstructive Lung Disorder
Musculoskeletal (muscles and bones)	☐ Rheumatoid Arthritis
Neurological (brain)	☐ Dementia/Alzheimer's ☐ Migraines ☐ Chronic Headaches
Genitourinary	☐ Kidney Disease
Endocrine (diabetes, thyroid, glands, etc.)	☐ Diabetes Type I ☐ Diabetes Type II ☐ Hypothyroidism
If you are diabetic Type I or Type II, what was your last blood sugar reading?	Fasting? ☐ Yes ☐ No
What is your A1C level?	Date:

Please provide your personal eye history.					
Disease	**Yes**	**Disease**	**Yes**	**Disease**	**Yes**
Amblyopia/Lazy Eye		Eye Injury		Other:	
Blindness/Low Vision		Glaucoma			
Cataracts		Macular Degeneration (AMD)			
Diabetic Retinopathy		Retinal Disease			
Dry Eye		Strabismus			

Please provide your surgical eye history.	
Procedure	**Yes**
Cataract Surgery	
LASIK Surgery	
Retinal Detachment	
Selective Laser Trabeculoplasty (SLT)	
Other:	

Please provide your family ocular history.	
(Mother, Father, Sibling, Maternal or Paternal Grandparent)	
Disease	**Family Member**
Blindness/Low Vision	
Diabetes / Retinopathy	
Glaucoma	
Macular Degeneration	
Social History – Tobacco Use	
What is your smoking status?	
Current smoker	☐ Yes
Former smoker	☐ Yes
Never smoked	☐ Yes

Please list all medications you take, including any over-the-counter items (i.e. vitamins, supplements, etc.)			
Medication	**Dosage**	**Medication**	**Dosage**
Please list any allergies to medications:			