

Medical History Questionnaire

Name: _____ Date: ____/____/____ Family Physician: _____

Do you currently have any problems in the following areas? If "YES", provide information:

Present Illness	<i>Yes</i>	<i>No</i>	<i>Explanation, Date Diagnosed, & Treatment.</i>
Vision Complaints (Decreased Vision, Eye Strain)			
Vision Symptoms (Double Vision, Blurry Vision)			
Vision Loss (Macular Degeneration, Diabetic Retinopathy, Glaucoma)			
Allergy Eye			
Ocular Symptoms (Itching, Dry Eyes, Watery, Burning, Eye Infection, Iritis, Mucous Discharge, Eyelid Disease, Glare)			
Red Eye			
Eye Pain			
Floaters/Flashes			
Eye Turn			
Headaches			
Systemic Symptoms			

Have you ever been diagnosed with the following conditions? If "YES" provide information:

Condition	<i>Yes</i>	<i>No</i>	<i>Explanation, Date Diagnosed, & Treatment.</i>
Allergy (Seasonal, Food, Drug)			
Cardiovascular (Heart Disease, Cholesterol, Hypertension, Diabetes)			
Constitutional (Fever, Weight Loss, etc.)			
Endocrine (Hypothyroid, Gout, etc.)			
Gastrointestinal (Gall Bladder, Stomach Ulcers, Intestinal Disease, etc.)			
Genitourinary (Bladder Infections, Ovarian Cyst, Kidney Stones)			
Head (Ears, Nose, Throat, Sinus, Ear Infection, Chronic Cough)			
Hematologic/Lymphatic (Anemia, Leukemia, Varicose Veins)			
Immunologic (Tuberculosis, AIDS, HIV, Herpes)			
Integumentary (Skin, Acne, Warts, Skin Cancer)			
Musculoskeletal (Arthritis, Osteoporosis, Lupus)			
Neurological (Bell's Palsy, Seizures, Brain Tumor, Vertigo)			
Psychiatric (Anxiety, Bi-Polar, Depression)			
Respiratory (Asthma, Emphysema, Bronchitis, Pneumonia)			

Please list current medications and the condition for which it is being taken:

Current Medication(s):

Condition:

Medication Allergies:

Please Fill Out Back of Page

