MEDICAL HISTORY QUESTIONNAIRE

Patient given name: _____ Today's Date: _____

Patient preferred name: _____ Date of Birth: _____

SOCIAL HISTORY

Occupation: _____

Hobbies: _____

Education Level: □ n/a (minor) □ High School Graduate/GED □ College Graduate □ Post Graduate

How many alcoholic drinks do you drink on average per day?

□ non-drinker □ social/occasional drinker □ one □ two □ three □ four □ five or more

What is your smoking status? □ non-smoker □ smokeless □ cigarette □ cigar □ pipe

Average number of packs a day: _____ Year quit: _____ Number of years smoked: _____

Do you use illicit/street drugs? □ Yes □ No If yes, please list: _____

Have you had any of the following sexually transmitted diseases?

Gonorrhea □ Yes □No Syphilis □ Yes □No Chlamydia □ Yes □No AIDS □ Yes □No

FAMILY HISTORY

Please place an 'X' in the appropriate box as it applies to your blood relatives: □ **family history is unknown**

	None	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Blindness								
Cataracts								
Glaucoma								
Macular Degeneration								
Retinal Detachment								
Strabismus (crossed eye)								
Arthritis								
Diabetes								
Thyroid Disease								
Kidney Disease								
Heart Attack								
Stroke								
High Blood Pressure								
Cancer								
Other (please explain):								

♦ PLEASE TURN OVER AND COMPLETE OTHER SIDE ♦

PERSONAL HISTORY

Please check any that apply to you. **If it does not apply to you, please check the negative box.**

CARDIOVASCULAR
- □ angina or heart attack
- □ high blood pressure
- □ high cholesterol
- □ irregular heart beat
- □ poor circulation
- □ stroke
- □ other: _____
- □ negative

EARS, NOSE, THROAT
- □ loss of hearing
- □ ringing in ears
- □ sinus problems
- □ hoarseness
- □ other: _____
- □ negative

ENDOCRINE
- □ diabetes
- □ thyroid disease
- □ rheumatoid arthritis
- □ lupus
- □ graves disease
- □ multiple sclerosis
- □ other: _____
- □ negative

EYES
- □ blurred vision
- □ other changes in vision
- □ dryness
- □ glaucoma
- □ cataracts
- □ macular degeneration
- □ iritis/uveitis
- □ retinal detachment

(EYES CONT)
- □ strabismus (crossed eye)
- □ double vision
- □ ocular trauma
- □ wear glasses
- □ wear contact lenses
- □ other: _____

GASTROINTESTINAL
- □ poor appetite/over eating
- □ abdominal pain
- □ nausea or vomiting
- □ GERD or acid reflux
- □ Crohn's Disease
- □ other: _____
- □ negative

GENITOURINARY
- □ ever used Flomax (tamsulosin)
- □ ever used Cardura (doxazosin)
- □ ever used Hytrin (terazosin)
- □ abnl pap smear (women)
- □ abnl PSA (men)
- □ AIDS/HIV positive
- □ STD: _____
- □ other: _____
- □ negative

MUSCLE/JOINT/BONE
- □ osteoporosis
- □ arthritis
- □ pain, weakness
- □ other: _____
- □ negative

NEUROLOGIC
- □ blackouts or loss of consciousness
- □ headaches
- □ migraines
- □ Bell's palsy
- □ brain tumor
- □ dementia
- □ dyslexia
- □ epilepsy
- □ shingles/herpes zoster
- □ other: _____
- □ negative

PSYCHIATRIC
- □ depression
- □ bipolar disorder
- □ other: _____
- □ negative

RESPIRATORY
- □ shortness of breath
- □ persistent cough
- □ asthma
- □ other: _____
- □ negative

SKIN
- □ easy bruising
- □ change in moles
- □ other: _____
- □ negative

Medications (including over the counter and eye meds):_____

_____

_____

_____

Are you allergic to any medications? □ Yes □ No If yes, please list: _____

Other allergies (Latex, etc.): _____

Major illnesses/injuries (What do you take your medications for?): _____

_____

_____

Surgeries you have had in the past (including eye surgeries): _____

_____

_____

Hospitalizations and what they were for: _____

_____

Immunization status: _____

_____
Patient Signature

_____
Physician Signature

Office use:	Date Reviewed	Initials
	_____	_____
	_____	_____
	_____	_____
	_____	_____