

MEDICAL HISTORY QUESTIONNAIRE

CHART# _____

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

Height: _____ Weight: _____ Sex: Male / Female Primary Care Physician: _____

CONDITIONS:	Circle any and all conditions that apply to you or check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst, Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung, skin, colon, other _____	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

List all **OTHER** surgeries you have had:

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 Sibling Grandparent	Heart Disease yes no	Mother Father Sibling Grandparent
Macular Degeneration yes no	Mother Father Sibling Grandparent	Hypertension yes no	Mother Father Sibling Grandparent
Blindness yes no	Mother Father Sibling Grandparent	Stroke yes no	Mother Father Sibling Grandparent
Retinal Disorders yes no	Mother Father Sibling Grandparent	Thyroid Disease yes no	Mother Father Sibling Grandparent
Cataracts yes no	Mother Father Sibling Grandparent	Arthritis yes no	Mother Father Sibling Grandparent
Glaucoma yes no	Mother Father Sibling Grandparent	Cancer yes no	Mother Father Sibling Grandparent
Diabetes yes no	Mother Father Sibling Grandparent	Type of Cancer: _____	Mother Father Sibling Grandparent

Physician Signature: _____ Date: _____

*All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.*

MEDICAL HISTORY QUESTIONNAIRE

CHART# _____

Patient Name: _____ Date of Birth: _____ Date: _____

SOCIAL HISTORY:

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

RACE: Not Specified American Indian or Alaska Native Asian Black or African American
Native Hawaiian or other Pacific Island White Hispanic

ETHNICITY: Are you Hispanic or Latino or Spanish Origin? YES or NO

Do you use Tobacco? Never Smoked Current Smoker Former Smoker
Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other _____

LIST ANY DRUG ALLERGIES: _____

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

REVIEWED:

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			
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		___ Times a day ___ or PRN	___ Oral ___ Topical ___ Injection			

Staff	Date

Physician Signature: _____ Date: _____

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