



MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

Do you have allergies to any medications: YES NO

If YES, list the medications _____

List any eye surgeries you have had (cataract, glaucoma, retina): _____

Medical History

Do you currently have any problems in the following areas?

System	YES	NO	Details
General			
Ears/Nose/Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Skin			
Neurological			
Other			

Family History

M=Mother F=Father S=Sibling GP=Grandparent

Condition	YES	NO	Relationship	Condition	YES	NO	Relationship
Blindness				Diabetes			
Glaucoma				High Blood Pressure			
Lazy eye				Cancer			
Other							

Social History

Do you drive? YES NO

Do you drink alcohol? YES NO If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? YES NO If YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Patient Signature _____ **Date** _____

Physician's Signature _____ **Date** _____