

Name: _____ Date of Birth: _____ Today's Date: _____

If new patient, how did you hear about our practice? _____

MEDICAL HISTORY QUESTIONNAIRE

What is the purpose of your visit today? _____

List **Medical Conditions**, surgeries, or injuries with dates:

List all **Medications** (include eye drops):

Medication Allergies: _____

Family Medical History (if yes, please include relationship):

Blindness _____ Heart Disease _____
Glaucoma _____ Arthritis _____
Macular Degeneration _____ Auto-immune _____
Retina _____ Cancer _____
Cataract _____ Diabetes _____
Other _____

Social History: Occupation: _____

Hobbies: _____
Alcohol: YES NO Smoking: YES NO
Drugs: YES NO
Have you fallen in the past year? YES NO
Flu vaccine this year? YES NO
Pneumococcal vaccine (age>65)? YES NO

Do you wear glasses? (Indicate if they are for reading, distance, or both): _____

Do you wear contacts? (Indicate what type and how often): _____

Have you had LASIK, PRK, or other refractive surgery? (Indicate where and when): _____

Review of Systems: Please circle if you have any issues with any of the following:

Eyes: Loss of Vision	Blurred Vision	Other: Diabetes	Thyroid issues
Double Vision	Fluctuating Vision	Environmental Allergies	Heart Disease
Dryness	Tearing	Runny nose/Sore throat	Hypertension
Sandy/Gritty	Red eye	Breathing/Asthma	Rapid Heart Rate
Crusty lashes	Discharge	Migraines	Sleep Apnea
Eye pain	Itching	Muscle/Joint Pain	Stomach Issues
Lazy Eye	Strabismus	Hearing Difficulties	Dry Mouth
Floaters	Flashes	Stroke/Mental Status	Dizziness
Lid swelling	Glare at night	Herpes	HIV