MEDICAL HISTORY QUESTIONNAIRE
REVIEW OF SYSTEMS

Name_____ Birth Date_____ Date_____

Do you have any problems in the following areas? If "Yes" please provide information.

EYES	Yes	No			Yes	No	
Loss of vision	___	___	_____	Red Eyes	___	___	_____
Blurred vision	___	___	_____	Itching	___	___	_____
Distorted vision (halos)	___	___	_____	Burning	___	___	_____
Loss of side vision	___	___	_____	Dryness	___	___	_____
Double vision	___	___	_____	Excess tearing	___	___	_____
Glare/Light Sensitivity	___	___	_____	Lazy eye	___	___	_____
Flashes of light	___	___	_____	Sties/Chalazion	___	___	_____
Floaters	___	___	_____	Eye Injury	___	___	_____
Eye Surgery	___	___	_____	Other_____			

		Yes	No	
CONSTITUTIONAL	Fever	___	___	_____
	Weight loss	___	___	_____
EARS, NOSE, MOUTH,	Sinus Congestion	___	___	_____
THROAT	Chronic cough	___	___	_____
	Dry throat/mouth	___	___	_____
	Runny nose	___	___	_____
	Hearing problems	___	___	_____
CARDIOVASCULAR	High blood pressure	___	___	_____
	Heart disease	___	___	_____
RESPIRATORY	Chronic Bronchitis	___	___	_____
	Asthma	___	___	_____
	Emphysema	___	___	_____
GASTROINTESTINAL	Stomach/intestines	___	___	_____
GENITOURINARY	Kidney/bladder/genitals	___	___	_____
ALLERGIES/ IMMUNOLOGIC				
	Head allergy symptoms	___	___	_____
	Seasonal allergies	___	___	_____
	Hay fever symptoms	___	___	_____
DERMATOLOGIC	Skin and/or breast	___	___	_____
NEUROLOGICAL	Stroke	___	___	_____
PSYCHIATRIC	Mental Illness	___	___	_____
	Depression	___	___	_____
ENDOCRINE	Diabetes. insulin	___	___	_____
	Diabetes, non insulin	___	___	_____
	Thyroid	___	___	_____
HEMATOLOGICAL/LYMPHATIC				
	High Cholesterol	___	___	_____
	Lymph nodes	___	___	_____
	Swelling	___	___	_____
MUSCULOSKELETAL	Muscle pain	___	___	_____
	Joint pain/Arthritis	___	___	_____

(Please complete other side)

PAST HISTORY

Present a current list of medications or write them on the "Medical Record" form.

List all major illnesses and injuries_____

_____

List any surgeries you have had_____

_____

List any allergies to medications_____

_____

FAMILY HISTORY	(other than yourself)		
DISEASES	YES	NO	RELATIONSHIP TO PATIENT
Blindness	____	____	_____
Cataract	____	____	_____
Glaucoma	____	____	_____
Macular Degeneration	____	____	_____
Retinal Detachment	____	____	_____
Cancer	____	____	_____
Diabetes	____	____	_____
Heart Disease	____	____	_____
High blood pressure	____	____	_____

Other_____

SOCIAL HISTORY

Current occupation _____

Retired _____

Height _____ Weight _____

Do you drive?	Y	N	
Do you have difficulty seeing street signs?	Y	N	
Do you have any problems with night driving?	Y	N	
Do you drink alcohol?	Y	N	Amount per week _____
Do you use tobacco?	Y	N	Amount per week _____
Have you ever had a blood transfusion?	Y	N	

Date Reviewed	Physician Signature: I have reviewed and I agree with Medical History Questionnaire and Medication Record	Tobacco Cessation Counseling		Changes Made	
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N
_____	_____	Y	N	Y	N