MEDICAL HISTORY QUESTIONNAI

Name:_____ Date:_____ Primary & Referring Physician:_____

List any medications you are currently taking (prescription and over the counter): Including aspirin, etc._____

Please let us know whom to thank for referring you if this is your first visit_____

Do you have **allergies** to any medications? ☐ Yes ☐ No If YES, list the medications & the problems they caused:_____

ROS (Review of Systems)

Do you *currently* have any problems in the following areas? If "YES", provide information:

System	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (Fever, Weight loss, Other)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, TD.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
SKELETAL (Osteoporosis, arthritis)			
SKIN (Acne, warts, skin cancer, rash, etc.)			
NEUROLOGICAL/PSYCHIATRIC (Anxiety, depression, persistent headaches)			
BLOOD (Cholesterol, anemia, lupus, etc.)			

PAST EYE HISTORY AND RELATED SYSTEMIC CONDITIONS

Have you EVER been diagnosed with the following conditions? If "YES" indicate when diagnosed and treated.

Condition	YES	NO	Date Diagnosed and description of treatment
AGE RELATED MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
EYE INJURY			
EYE SURGERIES			
DIABETES			
HIGH BLOOD PRESSURE			
CANCER			
STROKE			
ARTHRITIS			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

Disease	YES	NO	Relationship to patient
BLINDNESS			
MACULAR DEGENERATION			
GLAUCOMA			
CATARACTS			
DIABETES			
CANCER			
HEART DISEASE			
HIGH BLOOD PRESSURE/OTHER			

SOCIAL HISTORY

Current Occupation: _____

Do you Smoke? ☐ Drink? ☐ Drugs? ☐ If yes to any, please describe _____

☐ Check here if you wrote on the back of this form

_____
Physician's Initials