

PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME _____
 SEX: M ___ F ___

Review of Systems:

Please circle any of the following health problems which you have or have had:

Cardiovascular	Ear/Nose/Throat	Genitourinary
Y N Heart Disease	Y N Hearing Loss	Y N Kidney
Y N Heart Attack, Date _____		Y N Bladder
Y N Angina	Respiratory	Y N Prostate
Y N Stroke, Date _____	Y N Lung Disease	Hematologic/Lymph
Y N High Blood Pressure	Y N Tuberculosis	Y N Anemia
Y N Elevated cholesterol	Y N Chest	Y N Bleeding
Endocrine	Musculoskeletal	Neurological/Psych
Y N Diabetes, yrs _____	Y N Arthritis	Y N Seizures
Y N Thyroid disease	Gastrointestinal	Y N Alzheimers
Skin and or breast problems	Y N Ulcer	Y N Depression
Y N Skin Cancer	Y N Colitis/Diverticul.	Y N Other
Y N Keloids/Scarring	Y N Liver/Hepatitis	
Constitutional		
Y N Weakness	Y N Weight Loss _____	

Past **MEDICAL HISTORY** - please list any major illnesses, injuries, prior operations, hospitalizations:

Please list all **MEDICATIONS** that you are currently taking, including eye drops, vitamins, herbals:

DOSAGE	FREQUENCY	OTHER INSTRUCTIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **ALLERGIC** to any medications? YES ___ NO ___ If yes, please list:

EYE HISTORY - please circle the items with which you have been diagnosed:

Cataracts	Y N	Macular Degeneration	Y N
Diabetic Retinopathy	Y N	Retinal Disorders	Y N
Glaucoma	Y N	Retinal detachment	Y N

Other problems please list: _____

EYE SURGERY/EYE TRAUMA - please list:

Right Eye _____ Left Eye _____
