

HEALTH HISTORY QUESTIONNAIRE

Name _____

Date _____

 Date of **Birth** _____

 Date of **last eye exam** _____

 List any medications you currently take (Rx and/or over-the-counter):

 Do you have allergies to any medications or substances (including Latex) **YES NO**
 If YES, list the medications or substances:

 List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

 List any surgeries you have had (cataract, appendectomy):

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

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss or gain, fatigue)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful or frequent urination, impotence, jaundice, prostate)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, eczema, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, thyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

 Has any member of your family had these diseases (circle all that apply)? **YES NO UNKNOWN**
Blindness, Cataract, Glaucoma, Diabetes, Stroke, Cancer, Thyroid Disease, Arthritis

 Other heritable disease:

SOCIAL HISTORY

 Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**

 Have you ever had a blood transfusion? **YES NO**

 Do you drink alcohol? **YES NO** If **YES**, how much? _____

 Do you smoke? **YES NO** If **YES**, how much? _____ How many years? _____

Patient Signature _____

Date _____