

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Family Physician: _____

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, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
SKELETAL (Osteoporosis, arthritis)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL/PSYCHIATRIC (Anxiety, depression)			
BLOOD (Cholesterol, anemia, lupus, etc.)			

List all **medications** and dosages you are currently taking (prescription and over the counter): _____

Do you have **allergies** to any medications? Yes No If YES, list the medications: _____

Do you currently wear any of the following: glasses contact lenses no corrective lenses

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			
OTHER			
UNKNOWN			

SOCIAL HISTORY

Current Occupation: _____ Hobbies: _____

Tobacco use: Tobacco smoker Smokeless tobacco user None

Would you like to receive information on any of the following?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> polarized sun lenses | <input type="checkbox"/> bifocal contact lenses | <input type="checkbox"/> computer glasses | <input type="checkbox"/> sports/hobby eyewear such as: |
| <input type="checkbox"/> thinner eyeglass lenses | <input type="checkbox"/> laser vision correction | <input type="checkbox"/> contact lenses | <input type="checkbox"/> hunting <input type="checkbox"/> biking |
| <input type="checkbox"/> multiple pair discounts | <input type="checkbox"/> sun glasses | | <input type="checkbox"/> fishing <input type="checkbox"/> golfing |
| | | | <input type="checkbox"/> shooting <input type="checkbox"/> exercise |
| | | | <input type="checkbox"/> other: _____ |