MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____ Date:_____

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: _____

List any medications you take (including Latisse, oral contraceptives, aspirin, over the counter medications and home remedies):

List any major injuries, surgeries, and /or hospitalizations you have had (including LASIK):_____

Are you pregnant and/or nursing? ☐ No ☐ Yes
Do you wear glasses? ☐ No ☐ Yes
Do you wear contact lenses? ☐ No ☐ Yes
Brand of contact lenses: _____

Family History:

Please note family history (parents, grandparents, siblings, children; living or deceased) for the following conditions. If yes, please specify who:

Blindness	No / Yes _____	Crossed or "Lazy" Eyes	No / Yes _____
Cataract	No / Yes _____	Diabetes	No / Yes _____
Glaucoma	No / Yes _____	Macular Degeneration	No / Yes _____
High Blood Pressure	No / Yes _____	Kidney Disease	No / Yes _____
Retinal Detachment	No / Yes _____	Lupus	No / Yes _____
Arthritis	No / Yes _____	Thyroid Disease	No / Yes _____
Cancer	No / Yes _____	Other_____	No / Yes _____
Heart Disease	No / Yes _____		

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL		**EAR, NOSE, MOUTH, THROAT**	
Fever, Weight Loss/Gain	No / Yes	Allergies/ Hay Fever	No / Yes
INTEGUMENTARY (SKIN)	No / Yes	Sinus Congestion	No / Yes
NEUROLOGICAL		Post-Nasal Drip	No / Yes
Headaches	No / Yes	Chronic Cough	No / Yes
Migraines	No / Yes	Dry Mouth/ Throat	No / Yes
Seizures	No / Yes	**RESPIRATORY**	
EYES		Asthma	No / Yes
Loss of Vision	No / Yes	Chronic Bronchitis	No / Yes
Blurred Vision	No / Yes	Emphysema	No / Yes
Distorted Vision/Halos	No / Yes	**VASCULAR/ CARDIOVASCULAR**	
Loss of Side Vision	No / Yes	Diabetes	No / Yes
Double Vision	No / Yes	High Blood Pressure	No / Yes
Dry Eyes	No / Yes	High Cholesterol	No / Yes
Mucous Discharge	No / Yes	Vascular Disease	No / Yes
Redness	No / Yes	**GASTROINTESTINAL**	
Sandy or Gritty Feeling	No / Yes	Chronic Diarrhea	No / Yes
Itching	No / Yes	Constipation	No / Yes
Foreign Body Sensation	No / Yes	**GENITOURINARY**	
Excess Tearing/ Watering	No / Yes	Kidney/Bladder	No / Yes
Glare/ Light Sensitivity	No / Yes	**BONES /JOINTS/ MUSCLES**	
Eye Pain or Soreness	No / Yes	Rheumatoid Arthritis	No / Yes
Flashes	No / Yes	**LYMPHATIC/ HEMATOLOGIC**	No / Yes
ENDOCRINE		Bleeding Problems	No / Yes
Thyroid Glands	No / Yes	Anemia	No / Yes
PSYCHIATRIC		**ALLERGIC/ IMMUNOLOGIC**	No / Yes
Depression	No / Yes	**OTHER**_____	No / Yes
Anxiety	No / Yes		

Social History

Do you use tobacco products? No / Yes / Quit
Alcohol or drug dependency? No / Yes / Quit
Have you ever been exposed or infected with: Gonorrhea, Syphilis, Hepatitis, HIV, Other STD? No / Yes

Patient Signature:_____ Date:_____

Reviewed on: Date_____/Initials_____ Date_____/Initials_____ Date_____/Initials_____ Date_____/Initials_____