MONTEREY BAY
EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

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Name _____ Date _____

Date of Birth _____ Date of **last eye exam** _____

List all medications you currently take (Rx and over-the-counter). _____

_____

Do you have allergies to any medications? **YES** **NO**

If **YES**, list the medications. _____

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

_____

List any surgeries you have had (cataract, appendectomy, etc.).

_____

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

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

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other: _____

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?_____

_____ _____

Physician's Signature Date