

Medical History Questionnaire

Date: ___/___/___

Name: _____ Date of Birth: ___/___/___ Social Security #: _____
 Address: _____ City: _____ St: _____ ZIP _____
 Home Phone #: _____ Work Phone #: _____ Age: _____ Sex: M F
 Medical Doctor's Name: _____ Date of last medical exam: _____
 Date of Last Eye Exam: _____ Where was your last exam? _____
 How did you hear about Danville Eye Center?

Do you have any allergies to any medications? YES NO If YES, please list medications below:	List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) below:
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List all major illnesses (**glaucoma, diabetes, high blood pressure, heart attack, stroke, etc.**) or injuries below:

List any medications you are currently taking (prescription and over-the-counter) below:

FAMILY HISTORY: Please check YES or NO if anyone in <i>your immediate family</i> has had any of the following conditions. If YES, please tell the relationship of the family member to you.	GENERAL HEALTH: Please check YES or NO for the following general health questions about <i>yourself</i> . If YES, please explain the condition and write the date the condition began.
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DISEASE	YES	NO	Relationship to Patient	General/Constitutional	YES	NO	Date/Description
Blindness				Fever			
Glaucoma				Weight Loss			
Cataracts				Allergic/Immunologic			
Cancer				Ears, Nose, Throat			
Diabetes				Cardiovascular			
Heart Disease or High Blood Pressure				Respiratory			
Kidney Disease				Gastrointestinal			
Lupus				Genital, Kidney, Bladder			
Stroke				Muscles, Bones, Joints			
Thyroid Disease				Skin			

SOCIAL HISTORY:
 Current Occupation: _____
 Women: Are you pregnant or nursing? YES NO
 Marital Status: Married Single Divorced
 Do you currently wear glasses? YES NO
 If YES, how old are your current glasses? _____
 Do you currently wear contact lenses? YES NO
 If NO, are you interested in contact lenses? YES NO
 Do you drive? YES NO
 Do you have problems with night vision? YES NO
 Do you have visual difficulty when driving? YES NO
 Are you interested in laser vision correction (i.e. LASIK)?
YES NO

Neurological	YES	NO	Date/Description
Psychiatric			
Endocrine			
Blood/Lymph			
Other			

Do you drink alcohol?
 If YES: occasional 1/day 2-3/day 4+/day
 Do you smoke?
 If YES: occasional 1/2 pack/day 1 pack/day 1+packs/day
 Do you take any drugs that are not prescription or over-the-counter? YES NO

Hobbies and Interests:
Computers Fishing Swimming Hunting
Racquetball Basketball Golfing Music
 Others: _____