EYE PHYSICIANS OF WASHINGTON

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MEDICAL HISTORY QUESTIONNAIRE

Name:	**Date**:
Date of Birth:	Date of last eye exam:
List any **medications** you currently take (prescription and over-the-counter):	
Do you have **allergies** to any medications? YES or NO If YES, please list:	
List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):	
List any **surgeries** you have had (cataract, appendectomy):	

REVIEW OF SYSTEMS: Do you currently have any problems in the following areas? If YES, please describe.	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL (fever, heat stroke, weight loss, weight gain, fatigue, etc.)			
EARS, NOSE, THROAT (poor hearing, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (frequent urination, infection, impotence, etc.)			
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, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
*FEMALES ONLY: Are you pregnant? Nursing?			

FAMILY HISTORY: (Mother, Father, Grandparent, Sibling)

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

Other heritable disease:

SOCIAL HISTORY:

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

Have you ever had a blood transfusion? YES or NO

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

Are you a current smoker? YES or NO If YES, how much: _____ Start Date: _____
Are you a previous smoker? YES or NO If YES, how much: _____ Stop Date: _____

Physician's Signature _____ Date _____