My medical history has not changed since my last visit, please initial: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List any medical problems that other doctors have diagnosed: _____

Do you take medications for any of these systems?

Gastrointestinal ☐ Yes ☐ No	Nervous ☐ Yes ☐ No	Endocrine (glands) ☐ Yes ☐ No
Ear/Nose/Throat ☐ Yes ☐ No	Urinary ☐ Yes ☐ No	Blood/Lymph ☐ Yes ☐ No
Cardiovascular ☐ Yes ☐ No	Muscles/Bones ☐ Yes ☐ No	Allergic/Immunologic ☐ Yes ☐ No
Respiratory ☐ Yes ☐ No	Headaches ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No
Eyes ☐ Yes ☐ No	Mental ☐ Yes ☐ No	Integumentary (skin) ☐ Yes ☐ No

Please Explain: _____

Diabetes ☐ Yes ☐ No ☐ Type I ☐ Type II Date of Diagnosis ____ /____/_____

Are you pregnant? ☐ Yes ☐ No

Do you currently smoke/drink alcohol? How much? _____

Allergies to medication ☐ Yes ☐ No If yes, which kind(s)? _____

Have you had any operations? ☐ Yes ☐ No If yes, what kind? _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of Drug	Strength	Frequency Taken	Reason

High Blood Pressure ☐ Yes ☐ No Relation_____

Diabetes ☐ Yes ☐ No Relation_____

Glaucoma ☐ Yes ☐ No Relation_____

Macular Degeneration ☐ Yes ☐ No Relation_____

Retinal Detachment ☐ Yes ☐ No Relation_____

Cataracts ☐ Yes ☐ No Relation_____

Family History

Personal Eye Information

Have you had any eye operations? ☐ Yes ☐ No If yes, when? _____

Have you had any eye injury? ☐ Yes ☐ No If yes, what kind and when? _____

Do you have any of the following?

Glaucoma ☐ Yes ☐ No	**Cataracts** ☐ Yes ☐ No	**Dry Eyes** ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No	**Black outs** ☐ Yes ☐ No	**Blurred Vision** ☐ Yes ☐ No

Keratoconus ☐ Yes ☐ No	**Retinal Detachment** ☐ Yes ☐ No	**Flashes of Light** ☐ Yes ☐ No
Floating objects ☐ Yes ☐ No	**Prescription glasses** ☐ Yes ☐ No	**Contact Lenses** ☐ Yes ☐ No

Are you interested in: ☐ **Contacts** ☐ **Lasik Vision Correction** ☐ **Eye Glasses** ☐ **Sunglasses**