ADULT MEDICAL HISTORY QUESTIONAIRE

Date of **Birth**:_____ **New Patient**-Date of Last Eye Exam:_____
List of **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, cerebral palsy, 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	Please circle all that apply, or fill in 'other'
GENERAL/CONSTITUTIONAL			Fever, Weight Loss/Gain, Unusually tired, Pregnant, Other:
EARS/NOSE/THROAT			Hearing difficulties, Earache, Stuffy Nose, Cough, Tonsillitis, Other:
CARDIOVASCULAR			High BP, Racing Pulse, Heart disease, Irregular Heart Beat, Other:
RESPIRATORY			Asthma, Congestion, Pneumonia, Oxygen Use, Short of Breath, Other:
GASTROINTESTINAL			Celiac Disease, GERD, Ulcers, Constipation, Crohn's Disease, Other:
GENITAL/KIDNEY/BLADDER			Painful Urination, Frequent Urination, Turner's Syndrome, UTI Other:
MUSCULOSKELETAL			Torticollis, JRA/JIA, Scoliosis, Marfan's Syndrome, Cramps, Other:
SKULL/FACIAL			Goldenhars, Treacher Collins, Crouzon Disease, Other:
SKIN			Warts, Jaundice, Rosacea, Port Wine Stain, Eczema, Rash Other:
NEUROLOGICAL			Down Syndrome, Epilepsy, Developmental Delay, Hydrocephaly Other:
PSYCHIATRIC			Anxiety, Bipolar, OCD, Depression, ADD, ADHD, Autism, RAD Other:
ENDOCRINE			Diabetes, Hyperthyroid, Kidney disease, Other:
HEMATOLOGIC/LYMPHATIC			Anemia, Von Willebrands, Sickle Cell, Other:
ALLERGIC/IMMUNOLOGICAL			Lupus, HIV, AIDS, Hives, Swelling, Redness, HSV Other:

FAMILY HISTORY (Mother, Father, Siblings)

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? _____

NAME:_____