

**Annual Medical History Questionnaire
Established Patient**



Patient Name: _____ Date: _____

Date of Birth: _____ Primary Care Physician: _____ Optometrist: _____

List or use our **patient medication log** on the back of this form to provide a list of any **NEW medications** you currently take (Prescription and Over-the-Counter): _____

Do you have any **NEW allergies** to any medications, since your last visit? Yes No If yes, please check all that apply:
 Penicillin (PCN) Sulfa Barbiturates Insulin Iodine or Contrast Dyes Aspirin, Ibuprofen & Naproxen
 Novocain, Lidocaine, Epinephrine General Anesthesia Anti-Seizure Medications Pain Medication (codeine, vicodin, celebrex, vioxx, lortab, etc.) Other: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.), **since your last visit**:

List any **surgeries** you have had **since your last visit** (cataract, appendectomy, etc.): _____

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

- Eyes (poor vision, eye pain, tearing, redness, etc.) No Yes _____
- Eye Disease (Cataract, Glaucoma, Macular Degeneration, Corneal, etc.) No Yes _____
- General / Constitutional (fever, heat stroke, weight loss, weight gain) No Yes _____
- Ears, Nose, Throat (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.) No Yes _____
- Cardiovascular (high BP, racing pulse, etc.) No Yes _____
- Respiratory (congestion, wheezing, short of breath, etc.) No Yes _____
- Gastrointestinal (stomach upset, diarrhea, ulcer, constipation, hernia) No Yes _____
- Genital, Kidney, Bladder (painful or frequent urination, impotence, yellow jaundice, etc.) No Yes _____
- Females – Are you pregnant? nursing? No Yes _____
- Muscles, Bones, Joints (joint pain, stiffness, cramps, swelling, arthritis) No Yes _____
- Skin (pimples, warts, growths, rash, etc.) No Yes _____
- Neurological (numbness, headache, seizures, paralysis, etc.) No Yes _____
- Psychiatric (anxiety, depression, insomnia) No Yes _____
- Endocrine (diabetes, hypothyroid, etc.) No Yes _____
- Blood / Lymph (bleeding, cholestolemia, anemia, problems related to blood transfusion, etc.) No Yes _____
- Allergic / Immunologic (sneezing, swelling, hives, redness, itching) No Yes _____
- STD (HIV, AIDS, Herpes, etc.) No Yes _____

Family History (Mother, Father, Grandparent, Sibling)

Are there any changes to your family medical status? (mark all that apply)? No Yes Unknown
 Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer
 Thyroid Disease Arthritis Other heritable disease: _____

Social History

Any changes in employment? No Yes If yes, describe: _____
Any changes in marital status or living arrangements? No Yes If yes, describe: _____
Do you drink alcohol? No Yes If yes, how much? _____ Do you smoke? No Yes If yes, how much? _____
Do you use drugs / medications not prescribed by a doctor? No Yes If yes, what? And how often? _____
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? No Yes
Do you currently wear glasses? No Yes Do you currently wear contacts? No Yes Are you interested in refractive surgery? No Yes

Patient Medication Log Form available on the back