

Medical History Questionnaire  
New Patient



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_ With Doctor: \_\_\_\_\_

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

Do you have any **allergies** to any medications?  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.): \_\_\_\_\_

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.**

- Eyes (poor vision, eye pain, tearing, redness, dryness, 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)  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)

Has any member of your family had these diseases (mark all that apply)?  No  Yes  Unknown  
 Blindness  Cataract  Glaucoma  Diabetes  Hypertension  Heart Disease  Stroke  Cancer  
 Thyroid Disease  Arthritis  Other heritable disease: \_\_\_\_\_

**Social History**

Have you ever had a blood transfusion?  No  Yes  
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 Have you ever had refractive surgery (LASIK, PRK, RK, IOL Implant, etc.)?  No  Yes If yes, what and when? \_\_\_\_\_  
If not, would you be interested in refractive surgery?  No  Yes

**Patient Medication Log Form available on the back**