Medical History Questionnaire

Legal Name:_____ Date of Birth:_____

Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( ) Email Address: _____

Occupation: _____ Family Doctor Name/Location: _____

Do you drink alcohol? Y ( ) / N ( ) Do you smoke? Y ( ) / N ( ) How much per day? _____

Did you ever have any sexually transmitted diseases? (AIDS, Chlamydia, etc …) Y ( ) / N ( )

Do you drive? Y ( ) / N ( ) Does your vision limit your daily activities? (driving, reading, working, etc.) Y ( ) / N ( )

Briefly describe the reason for your visit: _____

_____

List ALL **Drug Allergies** and their reactions:

_____

_____

_____

_____

_____

Are you allergic to TAPE / LATEX ? Y ( ) N ( )

List ALL **Surgeries** you have had including ALL **EYE Surgeries & Laser Treatments:**

_____

_____

_____

_____

_____

MEDICAL HISTORY: Do you have any of the following health issues? If so, please explain.

Constitutional (sudden weight loss/gain, fever, weakness) _____

Ear/Nose/Throat (hearing loss, ulcers, infections) _____

Cardiovascular (high blood pressure, heart disease, high cholesterol, stroke) _____

Respiratory (shortness of breath, asthma, emphysema, TB, COPD) _____

Gastrointestinal (diarrhea, indigestion, nausea/vomiting, hernia) _____

Genital, Kidney, Bladder (frequent urination, prostate, kidney stones) _____

Muscles, Bones, Joints (arthritis, back pain, stiffness, join pain, gout) _____

Skin (rashes, moles, skin cancer, lesions/bumps) _____

Neurological (Parkinson's, Alzheimer's, chronic headaches, seizures) _____

Psychiatric (anxiety, depression, bipolar disorder, etc.) _____

Endocrine (diabetes, thyroid conditions) _____

Blood/Lymph (bleeding, anemia) _____

Immunological (recurrent infections, herpes simplex, shingles, lupus) _____

Eye Diseases (glaucoma, cataract, AMD, lazy eye, retinal detachment) _____

Medication List

Patient Name: _____

Pharmacy Name and Location: _____

In order for us to give you the best possible care, we need a complete list of all of the medications you are currently taking. Please take a few moments to fill in the information below indicating the names of each medication, the milligrams (dosage) of each medication and how many times per day or week you take each medication.

Please include all VITAMINS, SUPPLEMENTS & EYEDROPS

	Medication Name	Dosage	How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

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GREEN APPLE EYE CARE

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