

MEDICAL HISTORY QUESTIONNAIRE

NAME _____ DOB ___ / ___ / ___ VISIT DATE ___ / ___ / ___

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack etc) or injuries (concussion, etc) you have had:

List any surgeries you have had (cataract, tonsillectomy, appendectomy) please include the date:

List all medications you are using at present, please include over the counter medications and vitamins:

Eye Medications

All Other Medications

Name	Dose	Freq.	Eye		Name	Dose	Freq.

Are you allergic to any food or medication? Yes ___ No ___ Are you allergic to latex? Yes ___ No ___

If yes please list the substance(s) with type or reaction:

To assist you in receiving your medications in a timely manner our practice sends prescriptions electronically. Please list the name and location of your pharmacy.

Pharmacy Name _____ Phone Number _____

Location: Address _____ City/State _____

Do you use Fort Bragg to obtain your medication? Yes No

If you use a mail order pharmacy please list that information here: _____

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP
Blindness			
Glaucoma			
Arthritis			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Cancer- Type			
Other			

SOCIAL HISTORY

Current occupation: _____ Retired Disabled Unemployed

Education: High School Vocational school College degree Other

Marital Status: Married Divorced/Separated Single Widowed

Living Arrangements: _____

Do you drive? Yes No

Do you drink alcohol? Yes No If yes: Occasionally 1 per day 2-3 per day 4+per day

Do you smoke? Yes No If yes: Occasionally 1/2 pack a day 1 pack a day 1+pack a day

Blood Type _____ Have you ever had a blood transfusion? Yes No

How did you hear about our practice?

Who referred you? _____

Patient Name (Please Print)

Signature of Patient or Responsible Party

Date

