Medical History Questionnaire

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can as this will allow Dr. Riemer to more accurately assess your eye health. If you have any questions, we will be glad to help you.

NAME: _____ DOB: _____ DATE: _____

Name of Family Doctor: _____ Updated: _____

Dr.'s Address: _____ Updated: _____

Dr.'s Phone: _____ Updated: _____

MEDICATIONS

List all medications you are currently taking, include eye drops:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

SOCIAL HISTORY

Occupation/school grade _____

Do you use tobacco? Y N Years _____ QTY _____

Do you use Alcohol? Y N Years _____ QTY _____

Other substances? Y N List _____

ALLERGIES

List all allergies to medications or other substances:

_____

_____

SURGERIES AND INJURIES

List all major injuries, surgeries or hospitalizations:

_____

_____

FAMILY HISTORY

Has anyone in your family been diagnosed with:

Blood Pressure	Y / N	Diabetes	Y / N
Glaucoma	Y / N	Macular Deg.	Y / N
Cataracts	Y / N		

Other Medical conditions: _____

_____

REVIEW OF SYSTEMS

Eyes **OK**_____

- ❑ Permanent Vision Loss
- ❑ Blurred Vision
- ❑ Loss of Side Vision
- ❑ Double Vision
- ❑ Dry Eyes
- ❑ Light Sensitive
- ❑ Eye Pain
- ❑ Chronic Infection
- ❑ Sties
- ❑ Eye Surgery
- ❑ Eye Injury
- ❑ Glaucoma
- ❑ Lazy Eye
- ❑ Cataracts
- ❑ Macular Degen.
- ❑ Retina Problems
- ❑ Other Eye Problems

Ears, Nose, Throat OK_____

- ❑ Hearing Loss
- ❑ Allergies/Hay Fever
- ❑ Dry Throat/Mouth
- ❑ Sinus Problems

Diabetic OK_____

Yr. Diagnosed_____

Controled? Y N

BS level_____

Bones / Joints / Muscles OK_____

- ❑ Rheumatoid Arthritis
- ❑ Osteo-Arthritis
- ❑ Fibromyalgia
- ❑ Other

Neurological OK_____

- ❑ Anxiety
- ❑ Depression
- ❑ Migraines
- ❑ Seizures
- ❑ MS
- ❑ Autism

Vascular / Cardio OK_____

- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ High Cholesterol
- ❑ Other

Cancer? NO_____

Pregnant? NO_____

Endocrine OK_____

- ❑ Hormone Replacement
- ❑ Thyroid

Respiratory OK_____

- ❑ Sleep Apnea
- ❑ Asthma
- ❑ Chronic Bronchitis
- ❑ Emphysema
- ❑ COPD

Skin Disorder OK_____

Gastrointestinal OK_____

- ❑ Ulcers/Reflux
- ❑ Other

Genito-urinary OK_____

- ❑ STD
- ❑ Kidney / Bladder
- ❑ Prostate

Blood Disorder OK_____

- ❑ Anemia
- ❑ Bleeding Problems

Psychiatric OK_____

- ❑ Alzheimer's
- ❑ Mental Disability
- ❑ Other

If you answered YES to any of the above or have a condition not listed, please explain: _____

_____

_____

_____