

# 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 \_\_\_\_\_  
 Controlled? 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:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_