

**FOX VALLEY OPHTHALMOLOGY
MEDICAL HISTORY QUESTIONNAIRE**

Name: _____ Birth Date: _____
 Today's Date: _____

Do you currently have any problems in the following areas? If "YES," please provide information:
 Explanation of problem:

- Ears, nose, mouth, throat YES/NO _____
- Cardiovascular (High Blood pressure) YES/NO _____
- Respiratory (lungs/breathing) YES/NO _____
- Chronic Bronchitis YES/NO _____
- Gastrointestinal (stomach/intestines) YES/NO _____
- Genitourinary (genitals/kidney/bladder) YES/NO _____
- Musculoskeletal (Arthritis) YES/NO _____
- Integument (skin and/or breast) YES/NO _____
- Neurological YES/NO _____
- Psychiatric YES/NO _____
- Endocrine (Diabetes) YES/NO _____
- Hematological/Lymphatics (Blood) YES/NO _____
- Allergic and Immunologic YES/NO _____

Allergic to any medications? Please list: _____

List any medications you take: _____

List all major illnesses, injuries and/or surgeries you have had in the past: _____

FAMILY HISTORY

Do any of your blood relatives have (or had) the following?:

Relationship to Patient

- Blindness YES/NO _____
- Glaucoma YES/NO _____
- Macular degeneration YES/NO _____
- Retinal detachment YES/NO _____
- Cancer YES/NO _____
- Diabetes YES/NO _____
- Stroke YES/NO _____
- Thyroid disease YES/NO _____
- Tuberculosis YES/NO _____
- Other YES/NO _____

SOCIAL HISTORY

Current occupation: _____

Do you drink alcohol? YES/NO If YES, How many glasses a day? _____

Do you smoke? YES/NO If yes, how many packs a day? _____

FOR IN-OFFICE USE ONLY BELOW LINE

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