FOX VALLEY OPHTHALMOLOGY
MEDICAL HISTORY QUESTIONNAIRE

Name:____ Birth Date:______________________________

Do you currently have any problems in the following areas? If "YES," please provide **Explanation of Problem.**

General Health YES/NO____
Cardiovascular (High blood pressure/cholesterol) YES/NO____
Ears, nose, mouth, throat YES/NO____
Respiratory(lungs/breathing/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 Thyroid YES/NO____
Diabetes: Type I _____ YES/NO ____
Type II _____

Insulin dependent YES/NO ____

Hematological/Lymphatics (Blood) YES/NO____
Allergic and Immunologic YES/NO____

Are you allergic to any medications? YES/NO

Please list: ___________________________
____
____

List any medications you take: _______________________
____
____
____

List surgeries you have had in the past____
____

FAMILY HISTORY Do/did any of your **Blood Relatives** have the following? Please list **Relationship to Patient**

Glaucoma YES/NO____
Cataracts YES/NO____
Macular degeneration YES/NO____
Retinal Disease YES/NO____
Blindness YES/NO____
Strabismus YES/NO____
Amblyopia YES/NO____
Diabetes YES/NO____
Cancer YES/NO____
Heart Disease/Stroke YES/NO____
Other YES/NO____
Other YES/NO____

SOCIAL HISTORY

Current occupation: ___________________

Do you drink alcohol? YES/NO If YES, How many glasses a day?______________________________________
Have you ever smoked? YES/NO ___________ Do you smoke? YES/NO If yes, how many packs a day?_______
How many hours a day do you spend on the computer?________