Medical history questionnaire

Name: _____ Nickname: _____ Date of Birth: __/__/__

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Parent/Guardian Name (if patient is under 18): _____

Preferred Contact ☐Home☐Cell☐Email Social Security number: _____

Gender: ☐ Male☐ Female

Primary Care Physician: _____ Pharmacy: _____

Have you seen Dr. Fuller before? _____

What is your primary reason for visit today? _____

Systemic Illnesses:

☐No history of illness	☐Colitis	☐Hearing Loss	☐Liver Disease	☐Prostate Disease
☐Anemia	☐CHF	☐Heart Disease	☐Lung Disease	☐Psychiatric Disorder
☐Ankylosing Spondylitis	☐COPD	☐Hepatitis	☐Lupus	☐Rheumatoid Arthritis
☐Arthritis	☐Crohn's Disease	☐Herpes Simplex/Zoster	☐Meningitis	☐Sjogren's Syndrome
☐Arrhythmia	☐Diabetes Type 1 / 2	☐High Blood Pressure	☐Migraine	☐Stroke
☐Asthma	☐A1C ___ CBG_____	☐High Cholesterol	☐MRSA	☐Syphillis
☐Bleeding Disorder	☐Eczema	☐Histoplasmosis	☐Multiple Sclerosis	☐Thyroid Disease
☐Cancer	☐Emphysema	☐HIV/AIDS	☐Osteoporosis	☐Toxoplamosis
☐Celiac Disease	☐Fibromyalgia	☐Kidney Disease	☐Polymyalgia	
☐Chicken Pox	☐Headache	☐Kidney Stones	☐Pregnant/Nursing	

Other Please specify: _____

Medications: Name Dosage Frequency

1. _____
2. _____
3. _____
4. _____
5. _____

Please put any additional medications at the bottom of page 2

Allergies: _____

Past Ocular History:

☐Cataract ☐Macular Degeneration ☐Glaucoma ☐Diabetic Retinopathy ☐Dry Eye
☐Eye Infection ☐Floater/Flashes of light ☐Iritis or Uveitis ☐Retinal defects or degenerations

Other (Please specify): _____
Ocular surgeries: _____

Social History (please mark all that apply)

Smoking ☐Current Every day Smoker ☐Current Some Days Smoker ☐Former Smoker ☐Never Smoked

Alcohol use: ☐Yes ☐No If yes, what and how often _____

Family Medical History (parents, siblings, and children): Please indicate who is affected

Cancer _____ Diabetes type 1 or 2 _____ Hypertension _____
Thyroid Condition: Hypo or Hyper _____ Cataract _____
Macular Degeneration _____ Glaucoma _____
Other (Please specify) _____

Review of Systems (Please mark all that apply currently)

Constitution
- ☐Developmental Disabilities
- ☐Cancer
- ☐Fatigue
- ☐Weight loss/gain

Eyes
- ☐Contact Lens Wearer
- ☐Eye Pain
- ☐Double Vision

Ears, Nose, Throat
- ☐Hearing Loss
- ☐Sinusitis
- ☐Dry Mouth

Neurological
- ☐Seizures
- ☐Muscle Weakness
- ☐Numbness
- ☐Cerebral Palsy
- ☐Migraine
- ☐Autism Spectrum Disorder

Psychiatric
- ☐Depression
- ☐Anxiety
- ☐Attention Deficit
- ☐Bipolar Disorder
- ☐Mood Swings
- ☐Difficulty Sleeping

Allergy/Immunologic
- ☐Hives
- ☐Itching

Cardiovascular
- ☐Chest Pain
- ☐Dizziness
- ☐Fainting Spells
- ☐Shortness of Breath

Respiratory
- ☐Difficulty Breathing
- ☐Coughing
- ☐Wheezing

Gastrointestinal
- ☐Ulcer
- ☐Acid Reflux

Genito-Urinary
- ☐Difficulty urinating
- ☐Blood in urine

Musculoskeletal
- ☐Stiffness
- ☐Joint pain /swelling

Integumentary
- ☐Rashes
- ☐Eczema
- ☐Rosacea

Endocrine
- ☐Increased thirst
- ☐Increased hunger
- ☐Increased urination

Heme/Lymph
- ☐Bruise / Bleed easily

Additional Medications:

_____
_____
_____