

# Ritz & Johnson

## MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DATE: \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_ Referred by: \_\_\_\_\_

List any **medications** you currently take (prescription and over-the-counter)

\_\_\_\_\_

\_\_\_\_\_

Do you have any **allergies** to any medications: YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, list the medications:

\_\_\_\_\_

\_\_\_\_\_

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc) or injuries (concussion, etc.):

\_\_\_\_\_

\_\_\_\_\_

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, etc.)

\_\_\_\_\_

**Do you currently have any problems in the following areas? If "YES" please provide information.**

	YES	NO	EXPLAIN
<b>EYES</b> (Glaucoma, cataract, retinal disease, lazy eye, etc.)			
<b>GENERAL/CONSTITUTIONAL</b> (Fever, weight loss/gain, fatigue, etc.)			
<b>EARS, NOSE, THROAT</b> (Sinus, ear infection, chronic cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (Heart, circulation, HTN, etc.)			
<b>RESPIRATORY</b> (Asthma, emphysema, etc.)			
<b>GASTROINTESTINAL</b> (Ulcers, intestinal disease, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b>			
<b>MUSCLES, BONES, JOINTS</b> (Arthritis, etc.)			
<b>SKIN</b> (Skin cancer, etc.)			
<b>NEUROLOGICAL</b> (Stroke, seizures, etc.)			
<b>PSYCHIATRIC</b> (Anxiety, depression, insomnia, etc.)			
<b>ENDOCRINE</b> (Diabetes, thyroid, etc.)			
<b>BLOOD/LYMPH</b> (Cholesterolemia, anemia, etc.)			
<b>ALLERGIC/IMMUNOLOGIC</b> (Hay fever, lupus, Sjogrens, etc.)			

### FAMILY HISTORY

M=mother

F=father

S=sibling

GP=grandparent

DISEASE	YES	NO		DISEASE	YES	NO	
Blindness				Cataracts			
Glaucoma				Arthritis			
Cancer				Diabetes			
Heart disease or hypertension				Kidney disease			
Lupus				Stroke			
Thyroid disease				Other			

### SOCIAL HISTORY

Occupation: Current or Retired from \_\_\_\_\_

Marital Status \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had a blood transfusion Yes \_\_\_\_\_ No \_\_\_\_\_

History reviewed by: \_\_\_\_\_

If YES, when? \_\_\_\_\_

Problem Sheet updated by: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_