EYE CLINIC OF GREAT FALLS

MEDICAL HISTORY QUESTIONNAIRE

PATIENT ____________________ I.D. # ____________________

Health History: Please indicate below the conditions that apply to you or run in your family.

Please indicate your general health: ❑ Good ❑ Fair ❑ Poor

Date of Last Physical Exam: ____________________

Primary Care Physician Name: ____________________

EYES (blurred vision, double vision, dryness, redness, burning, tearing, eye pain crossed eyes, itching, glaucoma, macular degeneration, cataracts, surgery, etc.) ❑ SELF ❑ FAMILY

EAR, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.) ❑ SELF ❑ FAMILY

CARDIOVASCULAR (high blood pressure, irregular heart beat, heart attack, etc.) ❑ SELF ❑ FAMILY

RESPIRATORY (congestion, COPD, etc.) ❑ SELF ❑ FAMILY

GASTROINTESTINAL (constipation, ulcers, diarrhea, etc.) ❑ SELF ❑ FAMILY

GENITAL, KIDNEY, BLADDER (frequent or painful urination, etc.) ❑ SELF ❑ FAMILY

MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, etc.) ❑ SELF ❑ FAMILY

SKIN (pimples, warts, growths, rash, etc.) ❑ SELF ❑ FAMILY

NEUROLOGICAL (numbness, headache, etc.) ❑ SELF ❑ FAMILY

ENDOCRINE (diabetes, thyroid, etc.) ❑ SELF ❑ FAMILY

BLOOD/LYMPH (cholesterolemia, anemia, etc.) ❑ SELF ❑ FAMILY

ALLERGIES, IMMUNOLOGIC (seasonal, food, pets, hives, etc.) ❑ SELF ❑ FAMILY

OTHER (Please indicate any other medical conditions that we should be aware of) ❑ SELF ❑ FAMILY

LIST MEDICATIONS

ALLERGY TO MEDS ❑ YES ❑ NO

LIST

I ACKNOWLEDGE THE ABOVE INFORMATION IF CURRENT AND CORRECT

Signature	Date	Signature	Date	Signature	Date
Signature	Date	Signature	Date	Signature	Date
Signature	Date	Signature	Date	Signature	Date