PEDIATRIC OPHTHALMOLOGY
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ADULT MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____

Do you have any problems in the following areas?

	Y	N
Skin		
Head		
Ears		
Nose		
Mouth		
Throat		
Neck		
Respiratory (Lungs, Asthma)		
Cardiovascular (Heart, Blood Vessels)		
Gastrointestinal (Stomach, Liver)		

	Y	N
Genitourinary (Urinary Infections, Kidney)		
Bones, Joints (Arthritis)		
Lymphatic (Lymph Nodes, Swelling)		
Blood (Bleeding Tendency)		
Allergy/Immunology		
Hypertension		
Thyroid Disease		
Infectious(Chicken Pox, Mumps, Hepatitis)		
Diabetes		
Psychiatric		

Do you have any major illnesses? YES NO
Have you ever been hospitalized? YES NO
Have you ever had surgery? YES NO
Are you on any medications? YES NO
If yes, please list _____

_____

_____

Are you allergic to any medications? YES NO
If yes, please list _____

FAMILY HISTORY

Are there any diseases in the family?

	Y	N
Blindness		
Cataract		
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Strabismus (Crossed Eyes)		
Amblyopia (Lazy Eye)		

	Y	N
Heart Disease/Hypertension		
Cancer		
Kidney Disease		
Liver Disease		
Thyroid Disease		
Stroke		
Other		

SOCIAL HISTORY

Present occupation _____

Do you smoke? YES NO If yes, how many packs per day? _____
Do you drink alcohol? YES NO If yes, how many drinks per day? _____
Do you use street drugs? YES NO If yes, please indicate what? _____