PEDIATRIC OPHTHALMOLOGY
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ADULT MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME_____ **DATE**_____

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? _____

PHYSICIAN'S SIGNATURE_____
DATE_____