ROCHESTER REGIONAL HEALTH | **Rochester Regional Health**
Reed Eye Associates

----- Patient Demographics -----

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ DATE: _____

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

_____

_____

Do you have allergies to any medications? ☐ Yes ☐ No If yes, please list: _____

List all major illnesses or injuries: _____

_____

List any surgeries you have had: _____

_____

Date of last eye exam: _____ Do you drive: ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No Do you wear glasses? ☐ Yes ☐ No

Occupation: _____ Hobbies: _____

Do you smoke? ☐ No / ☐ Yes – how much? _____ How long? _____ years

Are you having any problems with your eyes? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

GENERAL (if yes, explain in space provided)

		Explanation
Ears, Nose, Throat (sinus, cough, dry mouth, etc.)	☐ Yes ☐ No	_____
Cardiovascular (heart, blood pressure, stroke, etc.)	☐ Yes ☐ No	_____
Respiratory (asthma, emphysema, etc.)	☐ Yes ☐ No	_____
Gastrointestinal (stomach ulcers, intestinal, etc.)	☐ Yes ☐ No	_____
Genital, Kidney, Bladder	☐ Yes ☐ No	_____
Muscles, Bones, Joints (arthritis, etc.)	☐ Yes ☐ No	_____
Skin (acne, warts, skin cancer, etc.)	☐ Yes ☐ No	_____
Neurological (multiple sclerosis, headaches, Seizures, etc.)	☐ Yes ☐ No	_____
Endocrine (diabetes, thyroid, etc.)	☐ Yes ☐ No	_____
Blood, Lymph (high cholesterol, anemia, etc.)	☐ Yes ☐ No	_____
Allergic, Immunologic (hay fever, lupus, etc.)	☐ Yes ☐ No	_____
General Health (fever, weight gain or loss, unusually tired)	☐ Yes ☐ No	_____
Psychiatric (depression, anxiety, etc.)	☐ Yes ☐ No	_____

FAMILY HISTORY (Parents, siblings, grandparents)

Blindness	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No

Eye Doctor's Signature: _____ Date: _____ Time: _____