Montgomery Eye
PHYSICIANS

MEP Rev. 12/2009

MEDICAL HISTORY QUESTIONNAIRE
Please circle NO or YES

Name _____ **Date of Birth** _____ **Date** _____

Date of Last Eye Exam _____ **Family Physician** _____ **Referring Physician** _____

Medication Allergies **No Yes If yes, list:** _____

Have you ever taken the prescription medication Flomax®? No Yes If yes, when? _____

Major Illnesses – Have you been diagnosed with any of the following conditions within the past 5 years? *If so, please circle:*

Blindness	Cataract	Glaucoma	Diabetes	Arthritis
Heart Disease	Stroke	Cancer	Thyroid Disease	Hypertension

Other *(please be specific)* _____

Major Surgeries (Cataract, open heart surgery, appendectomy, etc.) _____

Do you CURRENTLY have any problems in the following areas? Please circle "no" *or* "yes" and provide dates & details.

General/Constitutional	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Heart, Blood Pressure	No	Yes	_____
Lungs	No	Yes	_____
Stomach/Intestines	No	Yes	_____
Kidney/Bladder/Genitals	No	Yes	_____
Muscles/Bones/Joints	No	Yes	_____
Skin	No	Yes	_____
Nervous System	No	Yes	_____
Diabetes/Pituitary/Glands	No	Yes	_____
Blood/Lymph	No	Yes	_____
Allergic/Immunologic	No	Yes	_____
Are you nursing or pregnant?	No	Yes	_____

Family History Has any member of your family (mother, father, grandparent, sibling) had any of these diseases? *If so, please circle:*

Blindness	Cataract	Glaucoma	Diabetes	Arthritis
Heart Disease	Stroke	Cancer	Thyroid Disease	Hypertension

Other inheritable diseases? _____

Social History Alcohol? No Yes If yes, how much? _____ Tobacco? No Yes If yes, how much? _____

PLEASE DO NOT WRITE BELOW THIS LINE

Reviewed by Technician/Physician – Initial and Date

Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date