Dr. Michael J. Onyon and Associates

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Date: _____________________

Medical History

Do you have any allergies to medications, dyes, foods, pollen, animals, etc.? ☐ No ☐ Yes If yes, explain:

____

List any medications you currently take (include over the counter, oral contraceptives, home remedies, vitamins, aspirin, etc.)____

____

List any surgeries and/or hospitalizations____

____

List any of the following that you have had: crossed eyes, drooping eyelid, protruding eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: ____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	________________________________
Cataract	☐	☐	☐	________________________________
Crossed Eyes	☐	☐	☐	________________________________
Glaucoma	☐	☐	☐	________________________________
Macular Degeneration	☐	☐	☐	________________________________
Retinal Detachment	☐	☐	☐	________________________________
Arthritis	☐	☐	☐	________________________________
Cancer	☐	☐	☐	________________________________
Diabetes	☐	☐	☐	________________________________
Heart Disease	☐	☐	☐	________________________________
High Blood Pressure	☐	☐	☐	________________________________
Kidney Disease	☐	☐	☐	________________________________
Lupus	☐	☐	☐	________________________________
Thyroid Disease	☐	☐	☐	________________________________
Other_______________	☐	☐	☐	________________________________

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ☐ Yes, I would prefer to talk to the doctor directly about the following:

Do you use tobacco products? ☐ No ☐ Yes If so, type/amount/how long __________________________

Do you drink alcohol? ☐ No ☐ Yes If so, type/amount/how long __________________________

Do you use illegal drugs? ☐ No ☐ Yes If so, type/amount/how long __________________________

Have you ever been exposed or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Please Continue on Reverse Side

Review of Systems

Do you currently, or have you ever had any difficulties with the following:

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Dryness/Itching/Burning	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Eyestrain	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle/Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia/Bleeding Problems	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

____

____

____

____

____

____

____

Patient or Guardian
Signature____Date:_______________

Doctor’s Initials: ____________