

249 SOUTH SIXTH STREET

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TELEPHONE (256) 546-4647

Medical History Questionnaire

Name: _____ Date: _____

Birth Date: ____/____/____ Last Medical Exam: ____/____/____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Name of Pharmacy: _____ Pharmacy Phone: _____

Medical History

Do you have any allergies to medications, food, etc.? No Yes If Yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any medical problems/diagnoses you have (i.e. High blood pressure, diabetes, etc.): _____

Are you pregnant and/or nursing? No yes

Do you wear glasses? No Yes If Yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If Yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other _____

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Do you drive? No Yes If Yes, do you have visual difficulty when driving? No Yes If Yes, please describe: _____

Do you have any specific visual needs for your work or hobby? No Yes If Yes, please describe: _____

Do you use tobacco products? No Yes If Yes, type/amount/how long: _____

Do you drink alcohol? No Yes If Yes, type/amount/how long: _____

Do you use any other drugs? No Yes If Yes, type/amount/how long: _____

Check if you have ever been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis

Please turn this form over and complete side two

Review of Systems

Do you currently, or have you ever, had any problems in the following areas? (If yes, please explain and list medications).

SYSTEM	NO	YES	?	EXPLANATION/MEDICATION
General/Constitutional				
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic				
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes				
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus (Crossed Eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Mouth, Throat				
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular				
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal				
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals, kidney, bladder)				
Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones/Joints/Muscles				
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic/Hematologic				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine				
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjogrens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other				
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Doctor's Signature: _____

Review Date: _____