Milliken Eye Care
7 New Driftway
Scituate, MA 02066

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

REVIEW OF SYSTEMS – CURRENT MEDICAL PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Asthma	☐ Arrhythmia	☐ Arthritis
☐ Cardiovascular	☐ Diabetes	☐ Gastrointestinal
☐ Head Trauma	☐ Heart Attack	☐ Hepatitis
☐ High Cholesterol	☐ HIV	☐ Hypertension
☐ Intestinal	☐ Muscular/Skeletal	☐ Neurological
☐ Respiratory	☐ Seizures	☐ Skin
☐ Stroke	☐ Other	
Have you ever had a blood transfusion?	☐ Yes	☐ No
Are you currently taking any medication*? (Please describe)*		
Do you have any allergies*? (Please describe)*		

REVIEW OF SYSTEMS – CURRENT EYE PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Burning	☐ Blurred Vision	☐ Double Vision
☐ Dryness	☐ Discharge	☐ Redness
☐ Itching	☐ Tearing	☐ Light Sensitivity
☐ Glare	☐ Chronic Infection	☐ Eye Pain
☐ Tired Eyes	☐ Sties	☐ Distorted Vision

HEALTH HABITS AND PERSONAL SAFETY	
☐ Do you drink alcohol	☐ Do you use tobacco?
☐ Do you live alone?	☐ Do you take vitamins?

FAMILY HISTORY		
Health status of your parents, siblings or children: Eye Diseases (i.e., Cataract, Glaucoma, Macular Degeneration, Retinal Detachment):	Problem	Relationship
Medical Problems (i.e., Diabetes, High Blood Pressure, Heart Disease, Cancer, Stroke, Arthritis, Autoimmune Disease):	Problem	Relationship

MILLIKEN EYE CARE PHYSICIAN SIGNATURE:	**DATE:**