

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List any **medications** you currently take (Prescription and over-the-counter): _____

Name of Medical Drs.: _____ Phone: _____

Do you have **allergies** to any medications? **YES** **NO**
 If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			

GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

M=Mother F= Father S=Sibling GP=Grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Marital status (married, divorced, single, widowed): _____

Do you drive?..... YES NO

Do you have visual difficulty when driving?.... YES NO

Do you have problems with night vision?..... YES NO

Have you ever tried to wear contact lenses?..... YES NO

Do you currently wear contact lenses?..... YES NO If YES, how long? _____

Do you currently wear glasses?..... YES NO If YES, how long have you had your current prescription? _____

Have you ever had a blood transfusion?..... YES NO

Do you drink alcohol?..... YES NO If YES: occasional 1 /day 2-3 /day 4+ /day

Do you smoke?..... YES NO If YES: occasional 1 /day 2-3 /day 4+ /day

Patient Signature _____ Date _____