

## MEDICAL HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

List any medications you currently take (prescription and over-the-counter):

\_\_\_\_\_

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 information.

	YES	NO	Explanation of Problem
<b>EYES</b> (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
<b>GENERAL/CONSTITUTIONAL</b>			
Fever			
Weight Loss			
Other			
<b>EARS, NOSE, THROAT</b> (Sinus, ear infection, chronic cough, dry mouth, etc.)			

CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, 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: \_\_\_\_\_

EDUCATION (HIGH SCHOOL, VOCATIONAL SCHOOL, COLLEGE DEGREE): \_\_\_\_\_

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 HAVE YOU WORN CONTACT LENSES? \_\_\_\_\_

DO YOU CURRENTLY WEAR GLASSES?  YES  NO

IF YES, HOW LONG HAVE YOU HAD THE CURRENT PRESCRIPTION? \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO If YES: occasional 1 per day 2-3/day 4+/day

DO YOU SMOKE?  YES  NO If YES: occasional 1/2 pack/day 1 pack/day 1+pack

HAVE YOU EVER HAD A BLOOD TRANSFUSION?  YES  NO

HISTORY REVIEWED.  NO CHANGES.  ADDITIONS AS NOTED ABOVE.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_