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 any **allergies** to any medications? Yes_____ No ______
If **yes**, list the medications: ____

List all major **illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injures (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
EYES 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 or Light Sensitivity			
Eye Pain or soreness			
Infection of eye or eyelid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
Ears Nose Throat (sinus or ear infection)			

	YES	NO	Explanation of Problem
CARDIOVASCULAR (heart, vessels, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach, ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLE, JOINTS, BONES (arthritis, etc.)			
SKIN (acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholestrolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, Sjogrens syndrome)			

FAMILY HISTORY **M=Mother** **F=Father** **S=Sibling** **GP= Grandparent**

DISEASE	YES	NO	RELATIONSHIP TO FAMILY
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):__________________________

Martial Status: (married, divorced, single, widowed): ___________________________

Living Arrangements: ____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty while 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 how often? _____________

Do you smoke? ☐ YES ☐ NO If yes how much? _____________

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

History reviewed: No Changes ____ Additions noted as above ____

Physicians Signature: _______________________________ **Date:** ____________________________

Updated on: Date: ___________________ Date:___________________ Date: ____________________