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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.

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

OVER PLEASE

	YES	NO	
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 GPF=Grand Parent Father GPM=Grand Parent Mother

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Arthritis, Cancer, Diabetes			
Heart disease or high blood pressure			
Kidney Disease, Thyroid Disease			
Lupus, Stroke			
Other			

SOCIAL HISTORY

Current occupation: ______________________

Special visual Demands (computer, welding, etc.): ______________________

Education (high school, vocational school, college degree): ______________________

Hobbies (golf, swimming, musical instrument, etc.): ______________________

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

History reviewed: No changes Additions as noted above

Physician's Signature: ______________________ Date: ______________