

MEDICAL HISTORY QUESTIONNAIRE - PLEASE FILL OUT BOTH SIDES

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
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/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
Ears, Nose, Throat (Sinus, ear infection, etc.)			

	YES	NO	Explanation of Problem
CARDIOVASCULAR (Heart, vessels, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
RESPIRATORY (Asthma, emphysema, 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.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			

FAMILY HISTORY			
	M = mother	F = father	S = sibling GR = 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
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: