Medical History Questionnaire

Name_____ Date_____

☐ NO Change since last Medical History Questionnaire: Please initial _____

Date of Birth _____ Date of last eye exam_____

List any medications you currently take (prescription and over-the-counter):
1)_____ 2) _____3)_____4)_____

Do you have allergies to medications? ☐ YES ☐ NO
If YES, please list the medications:
1)_____ 2) _____3)_____4)_____

Please list all major illnesses (stroke, cancer, diabetes, high blood pressure, heart condition, etc.) and injuries:
1)_____ 2) _____3)_____4)_____

Please list any surgeries you have had (cataract, heart surgery, pacemaker surgery):
1)_____ 2) _____3)_____4)_____

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 (with glasses or contact lenses, if wearing)			
Fluctuating vision			
Distorted vision			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation (irritation)			
Excess tearing/watering			
Glare/light sensitivity/halos			
Eye pain or soreness			
Infection of eye or eyelid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelids			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			

REVIEW OF SYSTEMS

	YES	NO	Explanation of Problem
CARDIOVASCULAR (Heart attack, high blood pressure, etc)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestine, etc.)			
GENITAL, KIDNEY, BLADDER, etc.			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, stroke)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (High cholesterol, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hayfever, lupus, HIV, etc)			
EARS, NOSE, MOUTH, THROAT (Sinus, infection, cough, etc)			

FAMILY HISTORY

DISEASE	YES	NO	**Relationship to Patient** (You)
Blindness			
Glaucoma			
Cataracts			
Macular Degeneration			
Amblyopia (lazy eye)			
Retinal Disease			
Strabismus			
Cancer (please specify type)			
Diabetes			
Heart disease			
High blood pressure			
Kidney disease			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation (if retired, former occupation):_____

Education (High school, vocational school, college degree):_____

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

With whom do you live? _____

Do you drive? ☐ YES ☐ NO

Do you have any 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

Date/Year you were *first* prescribed contact lenses? _____

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you worn the current prescription? _____

Do you drink alcohol? ☐ YES ☐ NO If **Yes**: (CIRCLE ONE) occasional 1 per day 2-3/day 4+/day

Tobacco Status? ☐ YES ☐ NO If **Yes**: (CIRCLE ONE) Current Never Former Unknown

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

Are you pregnant? ☐ YES ☐ NO Are you nursing? ☐ YES ☐ NO

Patient's Signature:_____ Date_____

Physician's Signature:_____ Date_____