

Medical History Questionnaire

Name _____ Date _____

Date of Birth _____ Date of last **eye exam** _____ by Dr. _____

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

Do you have any **allergies** to any medications? Yes No

If yes, please list the medications: _____

List all **major illnesses** (glaucoma, diabetes, heart attack, etc.) or injuries (concussions, etc.):

List any **surgeries** you have had (Ex: cataract, tonsillectomy): _____

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 eyes | | | |
| Drooping eye lid | | | |
| General / Constitutional | | | |
| Fever | | | |
| Weight Loss | | | |
| Other | | | |
| Ears, Nose, Throat (sinus, ear infection, chronic cough, dry mouth, etc.) | | | |

| | YES | NO | Explanation of problem. |
|--|-----|----|-------------------------|
| Heart and Blood (Heart, vessels, etc.) | | | |
| Lung (Asthma, emphysema, etc.) | | | |
| Gastrointestinal (stomach ulcers, intestinal disease) | | | |
| Genital, Kidney, Bladder | | | |
| Muscles, Bones, Joints (Arthritis, etc.) | | | |
| Skin (Acne, warts, skin cancer, etc.) | | | |
| Neurological (Stroke, multiple sclerosis, etc.) | | | |
| Psychiatric (Anxiety, depression, insomnia, etc.) | | | |
| Endocrine (Diabetes, thyroid, etc.) | | | |
| Blood / Lymph (cholesterolemia, anemia, etc.) | | | |
| Allergic / Immunologic (Hay fever, lupus, Sjogrens, AIDS) | | | |

Family History: Family problems? If "YES" please list: M= Mother F= Father S= Sibling GP= Grandparent

| Disease | YES | NO | Explanation of problem. |
|--------------------------------------|-----|----|-------------------------|
| Blindness | | | |
| Cataract | | | |
| Glaucoma | | | |
| Macular Degeneration | | | |
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart disease or high blood pressure | | | |
| Kidney disease | | | |
| Lupus | | | |
| Stroke | | | |
| Thyroid disease | | | |
| Other | | | |

Social History

Current occupation: _____ Education (highest level): _____

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

Do you drive? Yes No

Do you have visual difficulty when driving? Yes No

Do you drink alcohol? Yes No If yes, occasional more than 4/day

Do you smoke? Yes No If yes, how much per day _____

Have you ever had a blood transfusion? Yes No

Physician Signature

Patients Signature

Technician's Signature