

# 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 new allergies to any medications, since your last visit?      **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	Details
<b>EYES</b>			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
<b>GENERAL / CONSTITUTIONAL</b> (fever, weight loss, other)			
<b>EARS, NOSE, THROAT</b> (stuffy nose, ear ache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, etc.)			

(continued) If YES, please provide information.	<b>YES</b>	<b>NO</b>	<b>Details</b>
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, etc.)			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, etc.)			

<b>FAMILY HISTORY</b>				M = mother	F = father	S = sibling	GP = grandparent
<b>Disease</b>	<b>YES</b>	<b>NO</b>	<b>Relationship to Patient</b>				
Blindness							
<b>Glaucoma</b>							
<b>Arthritis</b>							
<b>Cancer</b>							
<b>Diabetes</b>							
<b>Heart disease or high blood pressure</b>							
<b>Kidney disease</b>							
<b>Lupus</b>							
Stroke							
Thyroid disease							
Other							

<b>SOCIAL HISTORY</b>							
Current occupation: _____							
Education (high school, vocational school, college degree): _____							
Marital status (married, divorced, single, widowed): _____							
Do you drive?	<b>YES</b>	<b>NO</b>					
Do you have visual difficulty when driving?	<b>YES</b>	<b>NO</b>					
Do you have problems with night vision?	<b>YES</b>	<b>NO</b>					
Do you currently wear glasses?	<b>YES</b>	<b>NO</b>	If YES, how long have you had your current prescription? _____				
Do you drink alcohol?	<b>YES</b>	<b>NO</b>	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	<b>YES</b>	<b>NO</b>	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_