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**
EYES			
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			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			

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

FAMILY HISTORY M = mother F = father S = sibling GP = 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): _____

Living arrangements: _____

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? _____

Do you currently wear glasses? YES NO If YES, how long have you had your current prescription? _____

Do you drink alcohol?	YES	NO	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: _____ *Date:* _____