

# MEDICAL HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ Date of last eye exam \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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: \_\_\_\_\_

Name of Medical Doctor \_\_\_\_\_ Dr's phone# \_\_\_\_\_ Last Medical Exam \_\_\_\_\_

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, HIV.) 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
<b>EYES</b> (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			
<b>GENERAL/CONSTITUTIONAL</b>			
Fever			
Weight loss			
Other			
<b>EARS, NOSE, THROAT</b> (Sinus, ear infection, chronic cough, dry mouth, etc.)			

**MORE QUESTIONS ON REVERSE SIDE**

<b>CARDIOVASCULAR</b> (Heart, vessels, etc.)			
<b>RESPIRATORY</b> (Asthma, emphysema, etc.)			
<b>GASTROINTESTINAL</b> (Stomach ulcers, intestinal disease, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b>			
<b>MUSCLES, BONES, JOINTS</b> (Arthritis, etc.)			
<b>SKIN</b> (Acne, warts, skin cancer, etc.)			
<b>NEUROLOGICAL</b> (Multiple sclerosis, etc.)			
<b>PSYCHIATRIC</b> (Anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (Diabetes, hypothyroid, etc.)			
<b>BLOOD/LYMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC/IMMUNOLOGIC</b> (Hay fever, lupus, Sjogrens, 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: \_\_\_\_\_

Marital Status (married, divorced, single, widowed): \_\_\_\_\_ Spouses last eye exam date \_\_\_\_\_

Do you have children? \_\_\_\_\_ What are their ages? \_\_\_\_\_ Last eye exam dates \_\_\_\_\_

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 have you worn contact lenses? \_\_\_\_\_

List any problems you are having with contact lenses \_\_\_\_\_

Brand of solutions you use: \_\_\_\_\_ Would you like to reduce your solution costs? \_\_\_\_\_

Do you currently wear glasses  YES  NO Age of your current prescription \_\_\_\_\_

List any problems you are having with your eyeglasses: \_\_\_\_\_

Do you use a computer? \_\_\_\_\_ Number of hours/day \_\_\_\_\_ Describe any difficulty you have with computer vision: \_\_\_\_\_

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

History reviewed.  No Changes.  Additions as noted above.

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