MEDICAL HISTORY QUESTIONNAIRE

NAME DATE

DATE OF BIRTH ______________________________ DATE OF LAST EYE EXAM _______________

REASON FOR YOUR OFFICE VISIT? ____

LIST OF ANY MEDICATIONS YOU CURRENTLY TAKE (PRESCIPTION AND OVER-THE-COUNTER):____

ARE YOU ALLERGIC TO ANY MEDICATIONS? 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			
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.)			
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, hyperthyroid, 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 BP			
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 (who do you live with) ______________________________

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 contacts?-----------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 currently Prescription? ______________

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

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

Signature ______________________________ Date ______________