

## MEDICAL HISTORY QUESTIONNAIRE

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of **Birth** \_\_\_\_\_ Date of **last eye exam** \_\_\_\_\_

List any medications you currently take (prescription and over-the counter): \_\_\_\_\_

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Do you have any **allergies** to any medications?                      YES                      NO

If YES, List the medications: \_\_\_\_\_

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List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.): \_\_\_\_\_

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List any surgeries you have had (cataract, tonsillectomy, appendectomy): \_\_\_\_\_

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Do you currently have any problems in the following areas? If **YES**, please provide information

	YES	NO
<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		
Flashes of light		
Black Spots		
Trouble seeing close		
Trouble seeing at a distance		
Previous injury to eye		

**Details**

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 old is your current prescription? \_\_\_\_\_

Are you interested in LASIK/Refractive surgery?                      YES      NO

	YES	NO	DETAILS
<b>GENERAL/CONSTITUTIONAL</b> (fever, weight loss, other)			
<b>EAR, 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.)			
<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, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia, etc.)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD/LYMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC/IMUNOLOGIC</b> (sneezing, swelling, redness, Itching, hives, etc.)			

**FAMILY HISTORY**

M=mother F= father S= sibling GP= grandparent

DISEASE	YES	NO	
Blindness			
Glaucoma			
Arthritis			
Retinal detachment			
Macular degeneration			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Other			

**SOCIAL HISTORY**

Current occupation: \_\_\_\_\_

Marital status (married, divorced, single, widowed): \_\_\_\_\_

Do you drive? YES NO

Do you have visual difficulty while driving? YES NO

Do you have problems with night vision? YES NO

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 1/day 2-3/day 4+/day