MEDICAL HISTORY QUESTIONNAIRE

Patient Name_____ Date _____ Chart #_____
Family Dr. _____ Referring Dr. _____ Last eye exam _____
List any **medications** (including eye drops) you currently take (Prescription or over the counter):

_____

_____

List any **allergies** to medications:_____
List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, pregnancy, etc.)_____

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, etc.) _____

_____

Do you ***currently*** have any problems in the following areas? (If "yes", please provide explanation)

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Double vision			
Decreased or blurred vision spells			
Eye pain			
Floaters in your vision			
Flashing lights			
Eye injury			
Serious eye infection			
Dryness			
Sandy or gritty feeling			
Redness			
Mucous discharge			
Itching			
Burning			
Glare/light sensitivity			
Drooping eyelid			
In or out turning of eye, lazy eye			
GENERAL (fatigue, fever, weight loss)			
EARS, NOSE, THROAT (Sinus, ear infec., dry mouth)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Ulcers, Crohn's Disease, etc.)			
UROGENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, Stroke, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, Thyroid, etc.)			
BLOOD/LYMPH (High cholesterol, Anemia, HIV+)			
ALLERGIC/IMMUNOLOGIC (Hayfever, lupus, etc.)			

FAMILY HISTORY

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

	YES	NO	Relationship to Patient
Cataracts			
Glaucoma			
Diabetes			
Macular Degeneration			
Blindness			
Lazy Eye			
Other eye disorders			

SOCIAL HISTORY

Current Occupation?_____
Marital Status (married, divorced, single, widowed) _____
Do you drive? YES NO Do you have a problem with night vision? 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 pack/day 2-3 pack/day 4+ pack/day
Are you interested in Refractive Surgery (LASIK, Intacs)? YES NO
Are you interested in Contact Lenses? YES NO If YES: previous wearer ( ) or never worn ( )
Reviewer's Signature:_____