

# 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
<b>EYES</b> (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			
<b>GENERAL</b> (fatigue, fever, weight loss)			
<b>EARS, NOSE, THROAT</b> (Sinus, ear infec., dry mouth)			
<b>CARDIOVASCULAR</b> (Heart, vessels, etc.)			
<b>RESPIRATORY</b> (Asthma, emphysema, etc.)			
<b>GASTROINTESTINAL</b> (Ulcers, Crohn's Disease, etc.)			
<b>UROGENITAL, KIDNEY, BLADDER</b>			
<b>MUSCLES, BONES, JOINTS</b> (Arthritis, etc.)			
<b>SKIN</b> (Acne, warts, skin cancer, etc.)			
<b>NEUROLOGICAL</b> (Multiple Sclerosis, Stroke, etc.)			
<b>PSYCHIATRIC</b> (Anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (Diabetes, Thyroid, etc.)			
<b>BLOOD/LYMPH</b> (High cholesterol, Anemia, HIV+)			
<b>ALLERGIC/IMMUNOLOGIC</b> (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:** \_\_\_\_\_