Medical History Questionnaire

Name_____ Date_____
Date of Birth_____ Date of last **eye exam**_____ by Dr._____

List any **medications** you currently take (prescription and over the counter):_____
_____
_____

Do you have any **allergies** to any medications? ☐YES ☐NO
If yes, please list the medications:_____

List all **major illnesses** (glaucoma, diabetes, heart attack, etc.) or injuries (concussions, etc.):
_____

List any **surgeries** you have had (Ex: cataract, tonsillectomy):_____
_____

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

	YES	NO	Explanation of problem.
EYES (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 eye lid			
General/Constitutional			
Fever			
Weight loss			
Other			
Ears, Nose, Throat (Sinus, ear infection, chronic cough, dry mouth, Etc.)			

Heart and Blood (Heart, vessels, etc.)			
Lung (Asthma, emphysema, etc.)			
Gastrointestinal (Stomach ulcers, intestinal disease)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (Arthritis, etc.)			
Skin (Acne, warts, skin cancer, etc.)			
Neurological (Stroke, multiple sclerosis, etc.)			
Psychiatric (Anxiety, depression, insomnia, ect.)			
Endocrine (Diabetes, thyroid, etc.)			
Blood/Lymph (cholesterolemia, anemia, etc.)			
Allergic/Immunologic (Hay fever, lupus, Sjogrens, AIDS)			

Family History

Any family eye disease? If "YES" please list: M = mother F = Father S = Sibling GP = Grandparent

Disease	YES	NO	Explanation of problem.
Blindness			
Macular Degeneration			
Glaucoma			
Retinal Detachment			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

Social History

Current occupation:_____
Education (high school, vocational school, college degree):_____
Marital status (married, divorced, single, widowed):_____
Do you drive? ☐**YES** ☐**NO**
Do you have visual difficulty when driving? ☐**YES** ☐**NO**
Do you drink alcohol? ☐**YES** ☐**NO** **If yes,** ☐**occasional,** ☐**more than 4/day**
Do you smoke? ☐**YES** ☐**NO** **If yes, how much per day** _____
Have you ever had a blood transfusion? ☐**YES** ☐**NO**

_____ _____
Patients Signature Physician Signature

_____ ___/___/_____ MD review ___/___/_____MD review
Technician's Signature

___/___/_____ MD review ___/___/_____ MD review