MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **DOB:** _____

Pharmacy: _____

Location: _____

Are you allergic to any medications? ☐ No ☐ Yes **Sulfa** **Penicillin**

List others:

_____

PAST EYE HISTORY

Do you currently take any eye drops? ☐ No ☐ Yes **please list eye drops below:**

Name of Drop	Dosage	Frequency

Do you have any allergies to eye drops? ☐ Yes ☐ No List: _____
History of cataract, glaucoma ☐ Yes ☐ No _____
History of crossed/lazy eye ☐ Yes ☐ No _____
Eye injury or other trauma ☐ Yes ☐ No _____
Eye disease(s) ☐ Yes ☐ No _____
Eye surgery ☐ Yes ☐ No _____
Do you wear contact lenses? ☐ Yes ☐ No Type: Soft Hard Gas Permeable

List major illnesses:

- ☐ Heart disease
- ☐ Anemia
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Cold hands/feet
- ☐ Arthritis
- ☐ Depression
- ☐ Blood transfusion
- ☐ Tuberculosis
- ☐ Epilepsy/Seizures
- ☐ Headaches/migraines
- ☐ Cancer/type: _____
- ☐ Breathing problems/Asthma
- ☐ Previous head trauma
- ☐ Excessive weight loss/gain
- ☐ Kidney problems/stones
- ☐ HIV/AIDS
- ☐ Hepatitis A B C

Other:

_____

List any major surgical procedures:

_____

_____

_____

Medical History Questionnaire Page 2

PAST MEDICAL HISTORY

Please list all medications that you are currently using:

Name of Medication	Dosage	How taken

FAMILY HISTORY

OCULAR	YES	NO	RELATIONSHIP
Blindness	☐	☐	
Cataract(s)	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
MEDICAL			
Diabetes	☐	☐	
Other (list)	☐	☐	

SOCIAL HISTORY

Do you drink alcohol? ☐ ☐ How much? _____

Smoking status ☐ Current smoker ☐ Former Smoker ☐ Never smoked

How much per day? _____

Do you now or have you ever used illegal drugs? ☐ YES ☐ NO List: _____

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If YES, give an explanation.

EYES	YES	NO	EXPLANATION OF PROBLEM
Loss or blurred vision	☐	☐	
Itching, burning, or discharge	☐	☐	
Redness	☐	☐	
Gritty feeling/dryness/tearing	☐	☐	
Glare/light sensitivity or halos	☐	☐	
Infection of lids or styes	☐	☐	

Are any of the following activities difficult for you?

Driving ☐ Night vision ☐ Reading ☐ Daily activities ☐

X _____ _____

PATIENT/GUARDIAN SIGNATURE DATE