MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of birth _____ Date of last exam _____

List: any **medications** you currently take (prescriptions and over-the-counter):

_____

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

If YES, list the medications:

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **Injuries** (concussion, etc.):

_____

_____

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

_____

_____

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 or watering			
Glare or light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

OVER

	YES	NO	Explanation of Problem
GENERAL / CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, Vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intostinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

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

	YES	NO	RELATIONSHIP TO PATIENT
DISEASE			
Blindness			
Glaucoma			
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 have visual difficulty when driving? ☐YES ☐NO ☐DON'T DRIVE

Do you have problems with night vision? ☐YES ☐NO

Do you currently wear contact lenses? ☐YES ☐NO HOW LONG _____

Do you currently wear glasses? ☐YES ☐NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? ☐YES ☐NO If YES: occasional 1 per day 2-3 per day 4+ per day

Do you smoke? ☐YES ☐NO If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion? ☐YES ☐NO

History reviewed. ☐No Changes ☐Additions as noted

Physician's Signature: _____ Date: _____