MEDICAL HISTORY QUESTIONAIRE

Name _____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

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

_____

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

If YES, List the medications: _____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, 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
EYES		
Loss of vision		
Blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Glare or light sensitivity		
Loss of side vision		
Double vision		
Dryness		
Mucous discharge		
Redness		
Sandy or gritty feeling		
Itching		
Burning		
Foreign body sensation		
Excess tearing or watering		
Eye pain or soreness		
Infection of eye or lid		
Tired eyes		
Crossed eyes, lazy eye		
Drooping eyelid		
Flashes of light		
Black Spots		
Trouble seeing close		
Trouble seeing at a distance		
Previous injury to eye		

Details

Have you ever tried to wear contact lenses? YES NO

Do you currently wear contact lenses? YES NO If YES, how long? _____

Do you currently wear glasses? YES NO If YES, how old is your current prescription? _____

Are you interested in LASIK/Refractive surgery? YES NO

	YES	NO	DETAILS
GENERAL/CONSTITUTIONAL (fever, weight loss, other)			
EAR, NOSE, THROAT (stuffy nose, ear ache, cough, dry Mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, Cramps, etc.)			
SKIN (Pimples, warts, growths, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMUNOLOGIC (sneezing, swelling, redness, Itching, hives, etc.			

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

DISEASE	YES	NO	
Blindness			
Glaucoma			
Arthritis			
Retinal detachment			
Macular degeneration			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Other			

SOCIAL HISTORY

Current occupation: _____

Marital status (married, divorced, single, widowed): _____

Do you drive? YES NO

Do you have visual difficulty while driving? YES NO

Do you have problems with night vision? YES NO

Have you ever had a blood transfusion? 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/day 2-3/day 4+/day