

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

DATE: _____

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

Primary Care Doctor: _____ Eye Doctor: _____

What is the reason for your visit today? _____

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

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

If YES, please list: _____

List all major illnesses or injuries: _____

List all surgeries you have had: _____

REVIEW OF SYSTEMS

Do you currently have problems in the following areas?	YES	NO	Explain if Yes
GENERAL/CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
RESPIRATORY (shortness of breath, wheezing, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

EYE HISTORY			
	YES	NO	Explain if Yes
Have you had any Surgery on your eyes (cataract, laser, other)			
Do you use any eye drops on a regular basis? (Prescription or over the counter)			
Have you had any trauma to your eye?			
Do you have flashes of light or floaters?			
Vision Loss (Sudden or Gradual)			
Macular Degeneration			
Glaucoma			
Lazy Eye (amblyopia)			
Diabetic Retinopathy			
Retinal Detachment or Tear			

FAMILY HISTORY			
Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Cataracts			
Macular Degeneration			
Diabetes			
High blood pressure			
Cancer			
Other			

SOCIAL HISTORY							
Current occupation: _____							
Education (high school, vocational school, college degree): _____							
Marital status (married, divorced, single, widowed): _____							
Living arrangements: _____							
Do you drive?	YES	NO					
Do you have visual difficulty when driving?	YES	NO					
Do you have problems with night vision?	YES	NO					
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 long have you had your current prescription? _____				
Do you drink alcohol?	YES	NO	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: _____

Date: _____