MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: ____
Dateof Birth: ________________________________
Date of Visit: __________________________

Date of Last Eye Exam: ____________________

List Any Eye Medications/Drops You Currently Use: ____
____

List Any Other Medications You Currently Take: ____
____
____
____

List Any Allergies to **Medications**: ____
____

List All Major Illnesses (Glaucoma, Diabetes, High Blood Pressure, etc.) or Injuries (Concussion, etc.): ____________
____
____

List Any Eye Surgeries You Have Had (Cataract, LASIK, etc.) and Approximate Date: ________________________
____

List Any Other Surgeries You Have Had (Tonsillectomy, Appendectomy, etc.): ______________________________
____

Do you ***currently*** have any problems in the following areas? If **YES**, please explain.	**YES**	**NO**	**DETAILS**
EYE HISTORY			
Loss of vision			
Blurred Vision			
Fluctuating vision			
Double Vision			
Distorted Vision (halos)			
Glare or light sensitivity			
Visual difficulty when driving			
Problems with night vision			
Dryness			
Sandy or gritty feeling			
Redness			
Itching			
Burning			
Excess tearing or watering			
Eye pain or soreness			
Mucous Discharge			
Tired Eyes			

GENERAL HISTORY	YES	NO	DETAILS
General/Constitutional (fever, weight loss, etc)			
Ears, Nose, Throat (sinus, ear infection, etc)			
Cardiovascular (high blood pressure, heart, etc)			
Respiratory (congestion, wheezing, etc)			
Gastrointestinal (stomach upset, diarrhea, etc)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, etc)			
Muscles, Bones, Joints (joint pain, stiffness, etc)			
Skin (acne, warts, growths, rash, etc)			
Neurological (numbness, headache, etc)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc)			
Blood/Lymph (cholesterolemia, anemia, etc)			
Allergic/Immunologic (hay fever, etc)			

FAMILY HISTORY			M=Mother F=Father S=Sibling GP=Grandparent
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Age Related Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
Stroke			
High Blood Pressure			
Other			

SOCIAL HISTORY

Current Occupation: ____________________

Education: ____________________

Marital Status: ____________________

Living Arrangements (Nursing Home, Assisted Living, Rehabilitation, etc): ____________________

Alcohol Consumption: ☐ None ☐ Occasionally ☐ 1/Day ☐ 2-3/Day ☐ 4+/Day

Smoking Habits: ☐ None ☐ Occasionally ☐ 1/2 Pack/Day ☐ 1 Pack/Day ☐ 1+Pack/Day

Do You Drive? ☐ YES ☐ NO

Have You Ever Worn 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? ____________________

Patient's Signature: ____________________ *Date:* ____________________

Physician's Signature: ____________________ *Date:* ____________________