



# MEDICAL HISTORY QUESTIONNAIRE

NAME:

DATE:

Date of **Birth** \_\_\_\_\_ Date of **last eye exam** \_\_\_\_\_

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

Do you have new allergies to any medications, since your last visit? **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	Details
<b>EYES</b>			
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			
<b>GENERAL / CONSTITUTIONAL</b> (fever, weight loss, other)			
<b>EARS, NOSE, THROAT</b> (stuffy nose, ear ache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, etc.)			

(...continued) If YES, please provide information.	YES	NO	Details
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, etc.)			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, etc.)			

<b>FAMILY HISTORY</b>		M=mother F=father S=sibling GP=grandparent	
Disease	YES	NO	Relationship to Patient
Blindness			
<b>Glaucoma</b>			
<b>Arthritis</b>			
<b>Cancer</b>			
<b>Diabetes</b>			
<b>Heart disease or high blood pressure</b>			
<b>Kidney disease</b>			
<b>Lupus</b>			
Stroke			
Thyroid disease			
Other			

<b>SOCIAL HISTORY</b>							
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: \_\_\_\_\_