

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____
 DOB _____ Date of **last eye exam** _____ Optometrist _____
Family Doctor _____ Social Security Number _____ - _____ - _____
 List any **medications** you currently take (prescription 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 problems in the following? 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/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			SEE OTHER SIDE →

	YES	NO	
CARDIOVASCULAR(Heart, vessels, etc)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis)			
PSYCHIATRIC (Anxiety, depression, etc)			
ENDOCRINE (Diabetes, hypothyroid, etc)			
BLOOD/LYMPH (cholesterolemia, anemia)			
ALLERGIC/IMMUNOLOGIC			

FAMILY HISTORY

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

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Occupation **prior** to retirement: _____

Education (high school, vocational, college degree): _____

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

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 have you worn contact lenses? _____

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/day 4+/day

Do you smoke? _____ YES _____ NO If YES: occasional ½ pack/day 1 pack/day 1+pack

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

History reviewed No Changes Additions as noted above