

**Medical History Questionnaire**

**Patient Number** \_\_\_\_\_

Name: \_\_\_\_\_  
 Name of Eye Doctor: \_\_\_\_\_  
 Name of Medical Doctor: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_  
 Last Eye Exam: \_\_\_\_\_  
 Last Medical Exam: \_\_\_\_\_  
 Dr's Phone: (    )        - \_\_\_\_\_

**Medical History**

Do you have any allergies to medications?    yes  no  If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

Medications	Medications	Medications	Updated

List any of the following that you have had: crossed eyes, lazy eyes, drooping eyelids, prominent eyes, glaucoma, retinal disease, cataracts, eye infections eye surgery or eye injury: \_\_\_\_\_

Are you pregnant and/or nursing:     yes  no  
 Do you wear glasses:    yes  no     If yes, how old is your present pair of glasses? \_\_\_\_\_  
 Do you wear contact lenses:    yes  no     If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Type of contact lenses:     Rigid     Soft     Extended Wear     Other    Are they comfortable? \_\_\_\_\_  
 Do you drive:    yes     no     If yes, do you have visual difficulty when driving? \_\_\_\_\_

**Family History**

Where were you born: \_\_\_\_\_    What nationality/heritage are you: \_\_\_\_\_

Please note any family history (parents, grandparents, sisters, brothers, children: living or deceased) for the following

<u>Disease/Condition</u>	<u>yes</u>	<u>no</u>	<u>?</u>	<u>REL</u>	<u>Disease/Condition</u>	<u>yes</u>	<u>no</u>	<u>?</u>	<u>REL</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Retinal Detachment/Dis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—					

**Social History** This information is kept confidential. If you prefer to discuss this directly with the doctor check here.

Do you use tobacco products:? Yes  no  If, yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol? Yes  no  If, yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs? Yes  no  If, yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed or infected with? Gonorrhea  yes  no Hepatitis  yes  no

HIV  yes  no Syphilis  yes  no

Have you ever been exposed to any chemicals?  yes  no \_\_\_\_\_

**Review of Systems**

**Constitutional**                      **yes**      **no**      **?**

Fever Weight Loss/Gain

**Integumentary**

**Neurological**                                 

Headaches

Migraines

Seizures

**Eyes**

Loss of Vision

Blurred Vision

Distorted Vision/Halos

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

Sties or Chalazion

Flashes/Floaters in Vision

Tired Eyes

**Endocrine**

Thyroid/Other Glands

**Allergic/Immunologic**

**Psychiatric**

**Ears, Nose, Mouth, Throat**

**yes**      **no**      **?**

Allergies/Hay Fever

Sinus Congestion

Runny Nose

Post-Nasal Drip

Chronic Cough

Dry Throat/Mouth

**Respiratory**

Asthma

Chronic Bronchitis

Emphysema

**Vascular/Cardiovascular**

Diabetes

Chest Pain

High Blood Pressure

Vascular Disease

**Gastrointestinal**

Diarrhea

Constipation

**Genitourinary**

Genitals/Kidney/Bladder

**Bones/Joints/Muscles**

Rheumatoid Arthritis

Muscle Pain

Joint Pain

**Lymphatic/Hematological**

Anemia

Bleeding Problems

If you have answered YES to any of the above or have a condition not listed, please explain & list medications:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date