MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Birth Date:_____

Name of physician referring you:_____ Physician Phone:_____

Physician Address:_____ Date of last eye exam:_____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "YES", provide information:

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms	❑	❑	_____
Fever	❑	❑	_____
Weight Loss	❑	❑	_____
Other	❑	❑	_____
Eyes			
Loss of vision	❑	❑	_____
Blurred 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	❑	❑	_____
Occasional tearing	❑	❑	_____
Glare/Light sensitivity	❑	❑	_____
Eye pain or soreness	❑	❑	_____
Chronic infection of eye lid	❑	❑	_____
Sties, Chalazion	❑	❑	_____
Fluctuating visual acuity	❑	❑	_____
Tired Eyes	❑	❑	_____

	YES	NO	EXPLANATION OF PROBLEM
Ears, nose, mouth, throat			
Sinus congestion	❑	❑	_____
Runny nose	❑	❑	_____
Post-nasal drip	❑	❑	_____
Chronic cough	❑	❑	_____
Dry throat/mouth	❑	❑	_____
Cardiovascular (heart/blood vessels)	❑	❑	_____
Respiratory (lungs/breathing)	❑	❑	_____
Chronic bronchitis	❑	❑	_____
Gastrointestinal (stomach/intestines)	❑	❑	_____
Genitourinary (genitals/kidney/bladder)	❑	❑	_____
Musculoskeletal	❑	❑	_____
Muscle pain	❑	❑	_____
Joint pain	❑	❑	_____
Integument (skin and/or breast)	❑	❑	_____
Neurological	❑	❑	_____
Psychiatric	❑	❑	_____
Endocrine	❑	❑	_____
Hematological/Lymphatics	❑	❑	_____
Blood	❑	❑	_____
Lymph nodes	❑	❑	_____
Swelling	❑	❑	_____
Allergic and Immunologic	❑	❑	_____
Head allergy symptoms	❑	❑	_____
Seasonal allergies	❑	❑	_____
Hay fever symptoms	❑	❑	_____

PAST HISTORY

List any medications you take:_____

_____

List all major illnesses and injuries

_____

_____

List any surgeries you have had

_____

_____

Have you had crossed eyes, lazy eye, drooping eyelid or prominent eyes?_____

_____

_____

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

If YES, list medications_____

_____

_____

FAMILY HISTORY

DISEASES	YES	NO	RELATIONSHIP TO PATIENT
Blindness	❑	❑	_____
Cataract	❑	❑	_____
Glaucoma	❑	❑	_____
Macular degeneration	❑	❑	_____
Retinal detachment	❑	❑	_____
Arthritis	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Heart attacks	❑	❑	_____
High blood pressure	❑	❑	_____
Kidney disease	❑	❑	_____
Lupus	❑	❑	_____
Sjogrens Syndrome	❑	❑	_____
Stroke	❑	❑	_____
Thyroid disease	❑	❑	_____
Tuberculosis	❑	❑	_____
Other	❑	❑	_____

SOCIAL HISTORY

Current occupation: _____

Do you drive? ❑ YES ❑ NO

Do you have visual difficulty when driving? ❑ YES ❑ NO

Do you have a problem with night vision? ❑ YES ❑ NO

Have you ever tried to wear contacts? ❑ YES ❑ NO

Do you currently wear glasses? ❑ YES ❑ NO

If yes, how long have you had the current pair? _____

Do you drink alcohol? ❑ YES ❑ NO

If YES, how many glasses a day_____

Do you smoke? ❑ YES ❑ NO

If YES, how many packs a day_____

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

Have you ever been in contact with a person who had a sexually transmitted disease? ❑ YES ❑ NO

History reviewed ❑ No changes ❑ Additions as noted above

Physicians signature:_____ Date:_____