MEDICAL HISTORY QUESTIONNAIRE

Name **Date**

Date of **birth** Approximate date of last eye exam Where?:

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

List any **allergies** to medications

List all **major illnesses or injuries** (glaucoma, diabetes, high blood pressure, heart disease, concussion, etc.)

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, gall bladder, etc.)

Do you <u>**currently**</u> have any problems in the following areas? If "YES", please provide explanation

Eyes	Yes	No	Explanation of Problems
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted Vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Gritty, sandy feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing, watering			
Glare, light sensitivity			
Eye pain, soreness			
Infection, sty			
Tired eyes			
Crossed or lazy eye			
Drooping eyelid			
General/Constitutional			
Fever			
Weight loss			
Other			
Ears, Nose, Throat			
Sinus			

	Yes	No	Explanation of Problems
Cardiovascular (Angina, heart attack, poor circulation, etc.)			
Respiratory (Asthma, emphysema, bronchitis, TB, etc.)			
Gastrointestinal (Ulcer, Gastritis, diverticulitis, etc.)			
GU, Kidney, Bladder (Pyelonephritis, UTI, cystitis, etc.)			
Muscles, Bones, Joints (Arthritis, fractures, etc.)			
Skin (Acne, skin cancer, Rosacea, Scleroderma, etc.)			
Neurological (Seizures, MS, neuropathy, Parkinsons, etc.)			
Psychiatric (Depression, Anxiety, Schizophrenia, etc.)			
Endocrine (Diabetes, thyroid, pancreas, etc.)			
Blood/Lymph (High Cholesterol, anemia, leukemia, etc.)			
Allergic/Immunologic (Hay fever, HIV, Sjogrens, etc.)			
Are you HIV Positive?			

FAMILY HISTORY

Disease	Yes	No	Relationship to You
Blindness			
Glaucoma			
Cataract			
Diabetes			
Other Eye Disease			
Arthritis			
Cancer			
Heart Disease			
High Blood Pressure			
Stroke			
Kidney Disease			
Thyroid Disease			
Other			

SOCIAL HISTORY

Current Occupation ______________________

Education (highest grade achieved) ______________________

Marital Status (married, divorced, single, widowed) ______________________

Live at home, assisted living, rest home or other type of care ______________________

Do you drive? ______ ❑ YES ❑ NO

Do you have visual difficulty when you drive? ______ ❑ YES ❑ NO

Do you have problems with night vision? ______ ❑ YES ❑ NO

Do you currently wear glasses? ______ ❑ YES ❑ NO

If yes, how long have you had the current prescription? ______________________

Do you currently wear contact lenses? ______ ❑ YES ❑ NO If yes, how long? ______

Have you ever tried to wear contact lenses? ______ ❑ YES ❑ NO

Do you drink alcohol? ❑ YES ❑ NO If Yes: occasional 1/day 2-3/day 4+/day

Do you smoke? ❑ YES ❑ NO If Yes: occasional 10/day 1pack/day 1+pack/day

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

History reviewed ❑ **No Changes** ❑ **Additions as noted above**

Doctor's review: ______________________ Date: ______

New patient history form Aug 98