Medical History Questionnaire

Name_____Date_____

Last eye exam_____ Last physical_____

List all your medications you include dosage and frequency (Include vitamins and over the counter medicines):

_____ _____ _____ _____

_____ _____ _____ _____

Medicine Allergies?_____

List all major injuries, surgeries and/or hospitalizations_____

_____

-Have you been treated for any of the following conditions (please circle)? Crossed eyes lazy eye eye injury drooping eyelid prominent eyes glaucoma retinal disease cataracts eye infections

-Eye surgery (type/date)_____

-Have you been exposed to or infected with (circle): Hepatitis HIV Tuberculosis

-Do you have glasses/contact lenses? No Yes

-Are you pregnant or nursing? No Yes

REVIEW OF SYSTEMS problems with:

CONSTITUTIONAL

Fever, Weight Loss/Gain	No	Yes
(skin) acne problems	No	Yes

NEUROLOGICAL

Headaches/Migraines	No	Yes
Seizures	No	Yes
Neuropathy	No	Yes

EYES

Loss of Vision/Blurred Vision	No	Yes
Distorted Vision/Halos/Glare	No	Yes
Double Vision	No	Yes
Mucous Discharge/Watering	No	Yes
Redness /Burning	No	Yes
Sandy /Gritty Feeling/Dry	No	Yes
Itching	No	Yes
Glare/Light Sensitivity	No	Yes
Eye Pain or Soreness	No	Yes
Stye or Chalazion/Lid infection	No	Yes
Flashes/Floaters in Vision	No	Yes
Tired Eyes	No	Yes

ALLERGIC/IMMUNOLOGIC

Rosacea	No	Yes
Lupus	No	Yes
Fibromyalgia	No	Yes
Other_____	No	Yes

EARS, NOSE, MOUTH, THROAT

Allergies/HayFever/Sinus problem	No	Yes
Cough/Dry Throat/Mouth	No	Yes

RESPIRATORY

Sleep Apnea	No	Yes
Asthma/Bronchitis	No	Yes
COPD	No	Yes

VASCULAR/CARDIOVASCULAR

Diabetes I / Diabetes II	No	Yes
Year Diagnosed_____		
Heart/Vascular Problems	No	Yes
High Blood Pressure	No	Yes

GASTROINTESTINAL

Diverticulitis/GERD/Other	No	Yes
Diarrhea/Constipation	No	Yes

GENITOURINARY

STD	No	Yes
Genitals/Kidney/Bladder	No	Yes

BONES/JOINTS/MUSCLES

Rheumatoid Arthritis	No	Yes
Muscle Pain/Joint Pain	No	Yes

LYMPHATIC/HEMOTOLOGIC

Anemia/Bleeding Problems	No	Yes

PSYCHIATRIC No Yes

ENDOCRINE

Thyroid/Other Glands	No	Yes

SOCIAL HISTORY:

Do you drive?	No	Yes
Use tobacco products?	No	Yes
Drink alcohol?	No	Yes
Use other substances?	No	Yes

If Yes, Which ones?_____

How many 8 oz. Glasses of water do you drink daily?_____

Do you exercise routinely?_____

FAMILY HISTORY:

DISEASE/CONDITION

Blindness	No	Yes	Retinal Det./Disease	No	Yes	High Blood Pressure	No	Yes
Cataract	No	Yes	Arthritis	No	Yes	Kidney Disease	No	Yes
Crossed Eyes	No	Yes	Cancer	No	Yes	Lupus	No	Yes
Glaucoma	No	Yes	Diabetes	No	Yes	Thyroid Disease	No	Yes
Macular Deg.	No	Yes	Heart Disease	No	Yes	Other_____		

Comments or concerns:_____ Doctor's Signature _____Date_____

_____ _____ _____

_____ _____ _____

_____ _____ _____