MEDICAL HISTORY QUESTIONNAIRE

Today's Date: ______ / ____ / ____

Name ____ Date of Birth _____ / _____ / ____

Age _____ Ethnicity _____ Last Eye Exam: ____ / ____ / ____ Eye Doctor ______________________

Name of Medical Doctor ______________________________ Last Medical Exam _____ / ____ / ____

Were you referred by another doctor? ☐ Yes ☐ No Name of referring physician ____________________

REASON FOR TODAY'S VISIT: Please check all that apply

☐ Loss or change in vision	☐ Sandy/gritty sensation	☐ Eye pain
☐ Distorted vision or halos	☐ Itching	☐ Chronic infection of eye or lid
☐ Double vision	☐ Burning	☐ Sty or chalazion
☐ Dryness	☐ Foreign body sensation	☐ Flashes of light
☐ Mucous discharge	☐ Excess tearing or watering	☐ Floaters in vision
☐ Redness	☐ Glare or light sensitive	☐ Other - List below

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REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?
Constitutional			
Fever, Weight gain or loss	☐	☐	☐
Cardiovascular			
Heart condition or surgery	☐	☐	☐
High blood pressure	☐	☐	☐
Vascular or circulation problems	☐	☐	☐
Congested heart failure	☐	☐	☐
Ear, Nose, Mouth & Throat			
Allergies or hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Runny nose	☐	☐	☐
Post nasal drip	☐	☐	☐
Dry mouth or throat	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
COPD	☐	☐	☐
Chronic bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Tuberculosis	☐	☐	☐
Lung Disease	☐	☐	☐
Gastrointestinal			
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Cancer	☐	☐	☐
Genitourinary			
Kidney disease	☐	☐	☐
Bladder disease	☐	☐	☐

System	NO	YES	?
Musculoskeletal			
Rheumatoid arthritis	☐	☐	☐
Muscle / joint pain	☐	☐	☐
Multiple sclerosis	☐	☐	☐
Muscular dystrophy	☐	☐	☐
Integumentary			
Skin cancer	☐	☐	☐
Neurological			
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Epilepsy	☐	☐	☐
Psychiatric			
Depression	☐	☐	☐
Other	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid disease	☐	☐	☐
Hypoglycemia	☐	☐	☐
Hematologic / Lymphatic			
Anemia	☐	☐	☐
Blood disorders	☐	☐	☐
Leukemia	☐	☐	☐
Lyme disease	☐	☐	☐
Allergic / Immunologic			
Lupus	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Immune disorders	☐	☐	☐

** Please continue on other side **

SURGICAL HISTORY: Includes any surgery as well as eye surgery

Procedure	*Date of Surgery*	*Surgeon*

COMPUTER USAGE: *Do you work at a computer?* ☐ *Yes* ☐ *No* *Hours per day?* ________

PAST / PRESENT OCULAR HISTORY: ***Circle all that apply as well as a date the condition was diagnosed. Also, put down any blood relatives that have that same condition and their relationship to you.***

Condition	*Date Diagnosed*	*Family History*	*Condition*	*Date Diagnosed*	*Family History*
Glaucoma			Other		
Cataracts			Blindness		
Macular Degen.			Crossed Eyes		
Eye Injury			Diabetes		
Retinal Disease			Dry Eyes		

Do you wear glasses? ☐ ***Yes*** ☐ ***No*** ***Age of glasses*** ____________

Do you wear contact lenses? ☐ ***Yes*** ☐ ***No*** ***Age of contact lenses*** ____________

Type of contact lenses: ***Soft*** ***RGP/Hard*** ***Are your contact lenses comfortable?*** ☐ ***Yes*** ☐ ***No***

How often do you dispose of your contact lenses? ☐ ***1 day*** ☐ ***2 week*** ☐ ***1 month*** ☐ ***2 month*** ***Other*** ______

Other contact lens information you can provide ________________________________

SOCIAL HISTORY:

	Yes	***No***	***If yes, type / amount / how long***
Do you use tobacco products?	☐	☐	
Do you drink alcohol?	☐	☐	
Do you use illegal drugs?	☐	☐	
Have you ever been exposed to or infected with:			
Gonorrhea	☐	☐	
Hepatitis	☐	☐	
HIV	☐	☐	
Syphilis	☐	☐	
Tuberculosis	☐	☐	

What is your occupation? ________________________________

What are your hobbies? ________________________________

Do you drive? ☐ Yes ☐ No Any visual difficulty when driving? ____________________

Are you allergic to any medications? (Please list) ____________________

List any medications you currently take, name, dosage and frequency taken. This includes oral contraceptives, aspirin, over-the-counter meds and home remedies:

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____

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____

____

Are you pregnant and/or nursing? ☐ Yes ☐ No

For office use only:
Medical, Ocular, Social and Family History has been reviewed by ____________________ ____________
Doctor's Signature Date