

MEDICAL HISTORY QUESTIONNAIRE

PATIENT LEGAL NAME: _____

SSN: _____ SEX: M F DOB: _____

Date of most recent eye exam: _____ month _____ day _____ year

List any medications, prescription and over-the-counter, you are currently taking:

List any medications to which you are allergic: _____

List any surgeries you have undergone: _____

Have you or are you currently experiencing any problems with the following:

DISEASE OR CONDITION	Y	N	If yes, please describe.
VISION			
Glaucoma, cataract, retinal disease, etc.			
Loss of vision			
Blurred or fluctuating vision			
Loss of peripheral vision			
Distorted vision (halos) or double vision			
Dryness, itchiness, or sandy, gritty feeling			
Mucous discharge			
Redness or burning			
Foreign body sensation			
Excess tearing/watering			
Glare, sensitivity to light			
Soreness or pain			
Infection of eye or lid (Blepharitis, stye, etc.)			
Tired eyes			
Crossed or lazy eye (Strabismus)			
Drooping eyelid			
Other			
GENERAL / CONSTITUTIONAL (Fever, weigh loss or gain, etc.)			
EARS / NOSE / THROAT (Sinus/ear infection, chronic cough, dry mouth, etc.)			
CANCER			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcer, intestinal disease, etc.)			
GENITAL / KIDNEY / BLADDER			
MUSCLES / BONES / JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			

PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (Cholesterolemia, anaemia, etc.)			
ALLERGIES / IMMUNOLOGIC (Hay fever, lupus, Sjogren's Syndrome, etc.)			

Family History

(Please indicate relationship: F = Father M = Mother S = Sibling GP = Grandparent)

DISEASE OR CONDITION	Y	N	EXPLAIN / RELATIONSHIP TO PATIENT
Blindness, glaucoma, cataract			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Renal disease			
Lupus			
Heart attack or stroke			
Thyroid Disease			
Other			

Social History

Current Occupation: _____

Education (High school, vocational school, university): _____

Marital Status: Single Married Divorced / Separated Widowed

Living arrangements: Live alone Live with parent Roommate(s)

Do you drive? YES NO

Do you have vision difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Do you currently wear contact lenses? YES NO

If so, how long have you had your current prescription? _____

Do you currently wear glasses? YES NO

If so, how long have you had your current prescription? _____

Do you drink alcohol? Never Rarely/Socially Occasionally Often

Do you smoke? Never Rarely/Socially Occasionally Often

Have you ever had a blood transfusion? YES NO

Please include any other information you feel may be relevant: _____
