Medical History Questionnaire

General Patient Information

Name: Today's Date:

Date of Birth: _____ / _____ / _____ Date of Last Eye Exam: _____ / _____ / _____

Primary Care Physician:

Are you allergic to any medications? □ yes □ no If yes, please specify:

Below, please list all current medications you are taking: (including injections, eye drops, birth control, allergy meds, & hormones)

_____

_____

Eye History

Do you currently wear glasses? □ yes □ no If yes, how old are they? _____ If yes, for how many years?_____

Do you currently wear contacts? □ yes □ no If yes, how old are they? _____ If yes, for how many years?

Are you interested in Refractive Surgery (LASIK)? □ yes □ no

Social History

Current Occupation: Marital Status:

Hobbies:

Do you live alone? □ yes □ no Do you drive? □ yes □ no

Do you drink alcohol? □ yes □ no # of drinks per day?_____ Do you smoke? □ yes □ no # of packs per day?_____

Eyes (with your glasses and/or contacts, are you PRESENTLY having any difficulty doing any of the following activities?)

□ yes	□ no	Driving in bright light
□ yes	□ no	Driving in the dark
□ yes	□ no	Reading street/traffic signs
□ yes	□ no	Watching TV/movies
□ yes	□ no	Playing sports (tennis, golf, etc.)
□ yes	□ no	Stepping up/down curbs
□ yes	□ no	Working on the computer
□ yes	□ no	Reading small print
□ yes	□ no	Writing (checks, cards, etc.)
□ yes	□ no	Playing games (bingo, cards, etc.)
□ yes	□ no	Doing hobbies/fine handiwork

□ yes □ no Are you satisfied with your present vision.

Eyes (are you PRESENTLY having any of these symptoms?)

□ yes	□ no	Blurred or distored vision
□ yes	□ no	Sudden loss of vision
□ yes	□ no	Double vision
□ yes	□ no	Loss of side vision
□ yes	□ no	Redness
□ yes	□ no	Eye pain
□ yes	□ no	Discharge (watery, mucus, stringy)
□ yes	□ no	Sandy or gritty sensation
□ yes	□ no	Foreign body sensation
□ yes	□ no	Burning or stinging
□ yes	□ no	Itching
□ yes	□ no	Flashes and/or floaters
□ yes	□ no	Glare, light sensitivity, halos
□ yes	□ no	Crossed eyes
□ yes	□ no	Bump on eyelid or droopy lid

Please turn this page over and complete the opposite side.

Medical History (do you have any GENERAL medical problems in the following areas?)

□ yes	□ no	Fever
□ yes	□ no	Weight loss
□ yes	□ no	Headache
□ yes	□ no	Ear, nose, throat (sinus, ear infection, chronic cough, etc.)
□ yes	□ no	Cardiovascular (heart, vessels, etc.)
□ yes	□ no	Respiratory (asthma, emphysema, etc.)
□ yes	□ no	Gastrointestinal (ulcer, etc.)
□ yes	□ no	Genital, kidney, bladder
□ yes	□ no	Muscles, bones, joints (arthritis)
□ yes	□ no	Skin
□ yes	□ no	Neurological (multiple sclerosis, etc.)
□ yes	□ no	Psychiatric (anxiety, depression, etc.)
□ yes	□ no	Endocrine (diabetes, thyroid, etc.)
□ yes	□ no	Blood/lymph (cholesterol, anemia)
□ yes	□ no	Allergic/immunologic (hay fever, lupus, Sjogren's, etc.)

Family Medical History (do any of your blood relatives have health problems in the following areas?)

Please indicate who has these issues: M=mother F=father S=sibling GP=grandparent

Issue Present		Medical Issue	Family Relationship
□ yes	□ no	Blindness	_____
□ yes	□ no	Glaucoma	_____
□ yes	□ no	Arthritis	_____
□ yes	□ no	Cancer	_____
□ yes	□ no	Diabetes	_____
□ yes	□ no	Heart Disease	_____
□ yes	□ no	High Blood Pressure	_____
□ yes	□ no	Kidney Disease	_____
□ yes	□ no	Lupus	_____
□ yes	□ no	Stroke	_____
□ yes	□ no	Thyroid Disease	_____
□ yes	□ no	Lazy Eye	_____

Patient's Signature:

MD / OD Signature: