MEDICAL HISTORY QUESTIONNAIRE (PRIVATE AND CONFIDENTIAL)

Name of Patient (please print) ______________________________

Date of Birth ____/____/________

Occupation: ____________________________________

Date of Last Eye Exam: ____/____/________

Medical History:

Do you have any allergies to medications? ___ (N) ___ (Y) If yes, please list: ______________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): ____

____

List all major injuries, surgeries and/or hospitalizations you have had: ____________________________________

____

List any of the following that you have had: Crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury: ____

____

Are you pregnant and/or nursing? ___ (N) ___ (Y)

Do you wear glasses? ___ (N) ___ (Y) If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ___ (N) ___ (Y) Type? ___ Rigid ___ Soft Brand? ____________________

If you wear soft contact lenses, how often do you change them?
Daily / Weekly / 2 Weeks / Monthly / Quarterly / Yearly / Other _____________

Family History:

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	**NO**	**YES**	**?**	**RELATIONSHIP TO YOU**
Blindness	__	__	__	________________________________
Cataract	__	__	__	________________________________
Crossed Eyes	__	__	__	________________________________
Glaucoma	__	__	__	________________________________
Macular Degeneration	__	__	__	________________________________
Retinal Detachment/Disease	__	__	__	________________________________
Arthritis	__	__	__	________________________________
Cancer	__	__	__	________________________________
Diabetes	__	__	__	________________________________
Heart Disease	__	__	__	________________________________
High Blood Pressure	__	__	__	________________________________
Kidney Disease	__	__	__	________________________________
Lupus	__	__	__	________________________________
Thyroid Disease	__	__	__	________________________________
Other __________________	__	__	__	________________________________

(OVER)

Social History: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

___ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ___ (N) ___ (Y)

If yes, do you have visual difficulty when driving? ___ (N) ___ (Y) If yes, please describe: ________________

____

Do you use tobacco products? ___ (N) ___ (Y) Explain: ____

Do you drink alcohol? ___ (N) ___ (Y) Explain: ____

Do you use illegal drugs? ___ (N) ___ (Y) Explain: ____

Have you ever been exposed to or infected with: ___ Gonorrhea ___Hepatitis ___ HIV ___ Syphilis

Review of Systems:

Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	__	__	__
INTEGUMENTARY (Skin)	__	__	__
NEUROLOGICAL			
Headaches	__	__	__
Migraines	__	__	__
Seizures	__	__	__
EYES			
Loss of Vision	__	__	__
Blurred Vision	__	__	__
Distorted Vision/Halos	__	__	__
Loss of Side Vision	__	__	__
Double Vision	__	__	__
Dryness	__	__	__
Mucous Discharge	__	__	__
Redness	__	__	__
Sandy/Gritty Feeling	__	__	__
Itching	__	__	__
Burning	__	__	__
Foreign Body Sensation	__	__	__
Excess Tearing/Watering	__	__	__
Glare/Light Sensitivity	__	__	__
Eye Pain/Soreness	__	__	__
Chronic Infection Of Eye/Lid	__	__	__
Sties/Chalazion	__	__	__
Flashes/Floaters	__	__	__
Tired Eyes	__	__	__

System	NO	YES	?
ENDOCRINE			
Thyroid/Glands	__	__	__
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	__	__	__
Sinus Congestion	__	__	__
Chronic Cough	__	__	__
Dry Throat/Mouth	__	__	__
RESPIRATORY			
Asthma	__	__	__
Chronic Bronchitis	__	__	__
Emphysema	__	__	__
VASCULAR/CARDIOVASCULAR			
Diabetes	__	__	__
Heart Pain	__	__	__
High Blood Pressure	__	__	__
Vascular Disease	__	__	__
GASTROINTESTINAL	__	__	__
GENITOURINARY			
Genital/Kidney/Bladder	__	__	__
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	__	__	__
Muscle Pain	__	__	__
Joint Pain	__	__	__
LYMPHATIC/HEMATOLOGIC			
Anemia	__	__	__
Bleeding Problems	__	__	__
IMMUNOLOGIC	__	__	__
PSYCHIATRIC	__	__	__

If you answered YES to any of the above or have a condition not listed, please explain:

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