**Name:**_________________________________ **Date:**__________________

# MEDICAL HISTORY QUESTIONNAIRE

## MEDICAL HISTORY

Do you consider your health to be: Excellent Good Fair Poor (please circle one)

Do you have any allergies to medications? ☐ No ☐Yes Explain:_______________________

List all medications you take (i.e. oral contraceptives, aspirin, over the counter medications and home remedies): ☐ None ____________________________________________

____________________________________________

List all major injuries, surgeries and/or hospitalizations you have had in the last five years: ☐ None

____________________________________________

Circle any of the following that you have had: Crossed eyes, Lazy eye, Drooping eyelid, Prominent eyes, Glaucoma, Retinal disease, Cataracts, Eye infection, or Eye injury.

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

Do you wear glasses? ☐ No ☐ Yes If yes, how old are they?__________________

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old are they?__________________

Type of contact lenses: Rigid / Soft / Extended Wear / Other Are they comfortable? ☐ No ☐ Yes

## FAMILY HISTORY

*Please note family history (parents, grandparents, siblings, children; living /deceased) for these conditions*

| Disease/Condition | NO | YES | Relationship to you |
|---|---|---|---|
| Blindness | ☐ | ☐ | ____________________ |
| Cataract | ☐ | ☐ | ____________________ |
| Crossed Eyes | ☐ | ☐ | ____________________ |
| Glaucoma | ☐ | ☐ | ____________________ |
| Macular Degeneration | ☐ | ☐ | ____________________ |
| Retinal Detachment/Disease | ☐ | ☐ | ____________________ |
| Diabetes | ☐ | ☐ | ____________________ |
| High Blood Pressure | ☐ | ☐ | ____________________ |
| Other | ☐ | ☐ | ____________________ |

## SOCIAL HISTORY

*This information is kept confidential; however, if you prefer, you may discuss this portion directly with the doctor.*

☐ Yes, I prefer to discuss this information with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

____________________________________________

Do you use tobacco products? ☐ No ☐ Yes If yes, type/ amount/ how long?__________________

Do you drink alcohol? ☐ No ☐ Yes If yes, type/ amount/ how long?__________________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/ amount/ how long?__________________

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis (please circle)

## REVIEW OF SYSTEMS

*Please check boxes for any of the following current problem areas that are applicable to the patient:*

**EYES**
- Loss of Vision ☐
- Blurred Vision ☐
- Distorted Vision or Halos ☐
- Loss of Side Vision ☐
- Double Vision ☐
- Dryness ☐
- Mucous Discharge ☐
- Redness ☐
- Sandy / Gritty Feeling ☐
- Itching / Burning ☐
- Sties or Chalazion ☐
- Tired Eyes ☐
- Foreign Body Sensation ☐

**EYES (Continued)**
- Flashes / Floaters in Vision ☐
- Excess Tearing / Watering ☐
- Glare / Light Sensitivity ☐
- Eye Pain / Soreness ☐
- Chronic Infection of Eyes ☐

**IMMUNOLOGIC** ☐

**PSYCHIATRIC** ☐

**GASTROINTESTINAL**
- Diarrhea ☐
- Constipation ☐

**BONES / JOINTS / MUSCLES**
- Rheumatoid Arthritis ☐

**INTEGUMENTARY (skin)** ☐

**CONSTITUTIONAL**
- High Fever ☐
- Weight Loss / Gain ☐

**NEUROLOGICAL**
- Headaches ☐
- Migraines ☐
- Seizures ☐

**CARDIO-VASCULAR**
- Diabetes ☐
- Heart Attack ☐
- High Blood Pressure ☐
- Vascular Disease ☐
- Stroke ☐

**LYMPHATIC/HEMATOLOGIC**
- Anemia ☐
- Bleeding Problems ☐

**EARS / NOSE / THROAT**
- Allergies / Hay Fever ☐
- Sinus Congestion ☐

**RESPIRATORY**
- Asthma ☐
- Chronic Bronchitis ☐
- Emphysema ☐

**GENITOURINARY**
- Genitals / Kidney / Bladder ☐

**ENDOCRINE**
- Thyroid / Other Glands ☐

Please explain checked boxes from above:____________________________________________

____________________________________________

Doctor's Initials: _______/_______/_______/_______ Date: _______/_______/_______/_______