

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **Date of Birth:** _____ **Today's Date:** _____

Have you ever had any of the following medical problems?

Cataracts	Y	N	Glaucoma	Y	N
Retinal Detachment	Y	N	Crossed/Turned Eyes	Y	N
Dry Eyes	Y	N	Headache	Y	N
High blood pressure	Y	N	Heart disease	Y	N
High cholesterol	Y	N	Diabetes mellitus	Y	N
Asthma	Y	N	Emphysema	Y	N
Breathing problems	Y	N	Cancer	Y	N
Thyroid disease	Y	N	Autoimmune disease	Y	N
Arthritis	Y	N	Gastrointestinal disease	Y	N
Prostate disease	Y	N	Keloids/excessive scars	Y	N

Other: _____

Do you currently take any medications? Y N

If Yes, please list: _____

Are you allergic to any medication or food? Y N

If Yes, please list: _____

Do you wear glasses? Y N

Do you wear contact lenses? Y N

If Yes, soft or hard? _____ Brand: _____

For women only:

Are you pregnant? Y N Are you nursing? Y N

Do you currently have any problems in the following areas?			
If YES, please provide information.	YES	NO	Details
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD (anemia, clotting abnormality, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY		M = mother F = father S = sibling GP = grandparent	
Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY								
Current occupation: _____								
Education (high school, vocational school, college degree): _____								
Marital status (married, divorced, single, widowed): _____								
Living arrangements: _____								
Do you drive?		YES		NO				
Do you have visual difficulty when driving?		YES		NO				
Do you have problems with night vision?		YES		NO				
Do you drink alcohol?		YES	NO	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?		YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: _____

Date: _____