



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?)

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Driving in bright light |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Driving in the dark |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Reading street/traffic signs |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Watching TV/movies |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Playing sports (tennis, golf, etc.) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Stepping up/down curbs |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Working on the computer |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Reading small print |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Writing (checks, cards, etc.) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Playing games (bingo, cards, etc.) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Doing hobbies/fine handiwork |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Are you satisfied with your present vision. |

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

- | | | |
|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Blurred or distorted vision |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Sudden loss of vision |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Double vision |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Loss of side vision |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Redness |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Eye pain |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Discharge (watery, mucus, stringy) |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Sandy or gritty sensation |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Foreign body sensation |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Burning or stinging |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Itching |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Flashes and/or floaters |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Glare, light sensitivity, halos |
| <input type="checkbox"/> yes | <input type="checkbox"/> no | Crossed eyes |
| <input type="checkbox"/> yes | <input type="checkbox"/> 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

<u>Issue Present</u>	<u>Medical Issue</u>	<u>Family Relationship</u>
<input type="checkbox"/> yes <input type="checkbox"/> no	Blindness	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Glaucoma	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Arthritis	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Cancer	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Heart Disease	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	High Blood Pressure	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney Disease	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Lupus	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid Disease	_____
<input type="checkbox"/> yes <input type="checkbox"/> no	Lazy Eye	_____

Patient' s Signature:

MD / OD Signature: