MEDICAL HISTORY (2 PAGE) QUESTIONNAIRE

Name _____ Date:_____ Date of birth_____

List any medications you currently take (prescription and over the counter,) including eye drops, nasal sprays, inhalers, vitamins and herbs.

_____

_____

Do you have allergies to any medications, pollen, foods etc.? ❒ Yes(list below) ❒ No

_____

List all major illnesses and injuries including those of your eyes (glaucoma, diabetes, high blood pressure, heart attack, hepatitis, concussion, etc.)

_____

_____

List any surgeries you have had (cataract, lasik, cancer, coronary by-pass, etc.)

_____

_____

Do you **currently** have any problems in the following areas?

EYES	**YES**	**NO**	**Explanation of Problem**
Loss of vision			
Blurred vision			
Floaters or flashes of light			
Distorted vision or halos			
Double vision			
Trouble with night vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Glare or light sensitivity			
Eye pain or soreness			
Infection of eyes or lids (stye etc.)			
Tired eyes			
Crossed eyes or lazy eye			
Drooping eyelid			
Eye strain			

Do you wear glasses? _____How long have you had the current prescription(s)? _____
Use of glasses: ❒ Distance only ❒ Reading only ❒ Both ❒ Computer use
Do you see OK with your glasses? _____
Date of last eye exam? _____
If contact lenses: ❒ Hard ❒ Soft ❒ Soft Toric Remove them at bedtime? _____
Disposable?_____ If disposable, discarded every _____ weeks.

PLEASE TURN OVER TO COMPLETE

Do you **currently** have any problems in the following areas?

	YES	NO	Explanation of Problem
GENERAL / CONSTITUTIONAL			
Fever			
Weight loss			
Headaches			
EARS, NOSE, THROAT (Sinus, hearing loss, chronic cough, etc.)			
CARDIOVASCULAR (Heart, blood vessels, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
GASTROINTESTINAL (ulcers, intestinal or liver disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (arthritis, osteoporosis, etc.)			
SKIN (eczema, psoriasis, etc.)			
NEUROLOGICAL (stroke, MS, etc.)			
PSYCHIATRIC (depression, etc.)			
ENDOCRINE (diabetes, thyroid disease, etc.)			
BLOOD OR LYMPH (high cholesterol, anemia, etc.)			
ALLERGIC OR IMMUNOLOGIC (hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Retinal disease			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Autoimmune disease (lupus, etc.)			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Do you, or have you ever smoked:

❒ No ❒ Yes ❒ Quit How many years smoked?_____ Packs per day?_____

Do you drink alcohol?

❒ No ❒ Yes If yes: ❒ occasional ❒ 1-2 drinks per day ❒ 3+ drinks per day

Do you drink caffeinated beverages? ❒ No ❒ Yes

FOR WOMEN OF CHILDBEARING AGE

Are you pregnant? _____ Are you currently breast feeding? _____