

# MEDICAL HISTORY QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

MEDICAL DOCTOR'S NAME \_\_\_\_\_ DR. TELEPHONE # \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ DATE OF LAST EYE EXAM \_\_\_\_\_ REFERRED BY \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

ALLERGIES TO MEDICATION: CIRCLE YES / NO (if yes, please list) \_\_\_\_\_

Do you drive? Yes  No  Do you drink alcohol? Yes  No   
Do you have visual difficulty when driving? Yes  No  Do you smoke? Yes  No   
Have you ever had a blood transfusion? Yes  No  Do you wear glasses? Yes  No   
Do you wear contact lenses? Soft  Rigid  No

## Family History

Do you have a family history (parents, grandparents, siblings, children; living or deceased) for the following conditions?

Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cataract	Yes <input type="checkbox"/> No <input type="checkbox"/>
Crossed Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Retinal Detachment/ Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lupus	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other eye problems (please state) _____			

## Your Eye Health – General Health – Review of Systems

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

Blurred vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fever/chills/sweats	Yes <input type="checkbox"/> No <input type="checkbox"/>
Loss of vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Loss of side vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Double vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tired eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chest pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mucous discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>	Irregular heartbeat	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dryness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Wheezing/coughing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Redness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Itching	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gastrointestinal	Yes <input type="checkbox"/> No <input type="checkbox"/>
Burning	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint pain/arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye pain or soreness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rashes/skin ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	Migraines	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye injuries	Yes <input type="checkbox"/> No <input type="checkbox"/>	Strokes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Flashes/floaters in vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retinal detachment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glare/ light sensitivity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Genitourinary	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sandy or gritty feeling	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excess tearing, watering	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Foreign body sensation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes/blood sugar	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Macular degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seasonal allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other _____	Yes <input type="checkbox"/> No <input type="checkbox"/>