MEDICAL HISTORY QUESTIONNAIRE

Name ____ Date ________________

Date of **birth** ______________ Date of **last eye exam**______________

Chief complaint or problem that brings you to see us today ______________________

____

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____

List any **medications** you currently take (prescription and over-the-counter):

____

____

Do you have **allergies** to any medications? ☐ Yes ☐ No

If YES, list the medications:

____

List all **major illnesses** (diabetes type I or II, high blood pressure, heart disease/attack) or injuries, concussion:

____

____

List any **surgeries** you have had (cataract, **retinal problem or treatment**, tonsillectomy, appendectomy):

____

Do you ***currently*** have any problems in the following areas? If 'YES", please provide information.

EYES			**Explanation of Problem / Which EYE?**
Previous severe eye trauma	No	Yes	
Previous Retinal Surgery	No	Yes	
Flashes of light	No	Yes	
Floaters	No	Yes	
Diabetic Eye Disease	No	Yes	
Previous Eye Laser	No	Yes	
Retinal Detachment	No	Yes	
Macular Degeneration	No	Yes	
Cataract	No	Yes	
Previous Cataract Extraction/lens implant	No	Yes	
Glaucoma	No	Yes	
Loss of vision	No	Yes	
Blurred vision	No	Yes	
Fluctuating vision	No	Yes	
Distorted vision	No	Yes	
Loss of side vision	No	Yes	
Double vision	No	Yes	
Mucous discharge	No	Yes	
Redness	No	Yes	
Eye pain or soreness	No	Yes	
Crossed eyes, lazy eye	No	Yes	
Other eye problem	No	Yes	
GENERAL/CONSTITUTIONAL			
Fever	No	Yes	
Weight loss	No	Yes	

Over

Name ____________________ Date ______________

EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)	No	Yes	
CARDIOVASCULAR (Heart, vessels, etc.)	No	Yes	
RESPIRATORY (Asthma, emphysema, etc.)	No	Yes	
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)	No	Yes	
GENITAL, KIDNEY, BLADDER	No	Yes	
MUSCLES, BONES, JOINTS (Arthritis, etc.)	No	Yes	
SKIN (acne, warts, skin cancer, etc.)	No	Yes	
NEUROLOGICAL (Multiple sclerosis, etc.)	No	Yes	
PSYCHIATRIC (Anxiety, depression, insomnia)	No	Yes	
ENDOCRINE (Diabetes, hypothyroid, etc.)	No	Yes	
Is blood glucose under good control?	No	Yes	
BLOOD/LYMPH (cholesterolemia, anemia, etc.)	No	Yes	
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)	No	Yes	

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE			**RELATIONSHIP TO PATIENT**
Blindness	No	Yes	
Glaucoma	No	Yes	
Arthritis	No	Yes	
Cancer	No	Yes	
Diabetes	No	Yes	
Heart disease or high blood pressure	No	Yes	
Kidney disease	No	Yes	
Macular degeneration	No	Yes	
Stroke	No	Yes	
Retinal Detachment	No	Yes	
Other	No	Yes	

SOCIAL HISTORY

Current occupation: ______________________________ ☐ Full time ☐ Part time

Education (high school, vocational school, college degree): ______________________

Marital Status (married, divorced, single, widowed): ______________________

Do you drive? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Do you currently wear glasses for distance? ☐ Yes ☐ No

Do you currently wear glasses or bifocals to read? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Are you currently smoking? ☐ Yes ☐ No

Date of last flu shot ______________

Have you had pneumonia vaccine? Date ______________

Technician Signature: ______________ MD's Signature: ______________ Date: __________