

# Medical History Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Last eye exam \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Occupation \_\_\_\_\_

Please list any allergies to medications \_\_\_\_\_

**Diabetes Yes/No Type \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_ Last Blood Sugar Reading \_\_\_\_\_**

## **Eyewear Information (check all that apply)**

- |  |   |
|--|---|
| _____ Use a computer for work or fun   | _____ Work out in the sun                   |
| _____ Work with small figures or print | _____ Difficulty seeing to read             |
| _____ Need protective eyewear at work  | _____ Active in sports                      |
| _____ Student                          | _____ Want contact lenses                   |
| _____ Difficulty driving at night      | _____ Sensitive to sunlight or bright light |
| _____ Difficulty watching television   | _____ Difficulty seeing at arm's length     |

## **Eye Information: (Please circle yes or no.)**

Do you have any eye conditions or problems? Yes/No Explain \_\_\_\_\_

Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Yes/No Explain \_\_\_\_\_ Date \_\_\_\_\_

Do you have glaucoma? Yes/No	Cataracts	Yes/No	Macular Degeneration	Yes/No
Dry Eyes (sandy/gritty) Yes/No	Retinal Detachment	Yes/No	Blurred Vision	Yes/No
Excess Tearing Yes/No	Red Eyes	Yes/No	Itching/Burning	Yes/No
Eyelid soreness Yes/No	Mucous Discharge	Yes/No	Light Sensitivity	Yes/No
Double Vision Yes/No	Drooping Eyelid	Yes/No	Flashes/Floaters	Yes/No
Do you wear glasses? Yes/No	Contact lenses?	Yes/No	Type _____	

## **Medical Information:**

Do you have any problems with any of these systems?

Blood/Lymph Yes/No	Headaches	Yes/No	Respiratory	Yes/No
Cardiovascular Yes/No	High Blood Pressure	Yes/No	Skin	Yes/No
Ears/Nose/Throat Yes/No	Immunologic	Yes/No	Urinary	Yes/No
Endocrine (Glands) Yes/No	Mental	Yes/No	Pregnant/Nursing	Yes/No
Gastrointestinal Yes/No	Muscles/Bones	Yes/No	Other _____	

Please explain any YES answers: \_\_\_\_\_

List all medications you take, including over the counter medications and home remedies: \_\_\_\_\_

List all major injuries, surgeries, and/or hospitalizations \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

## **Family History:**

High blood pressure	Yes/No	Relation _____	Diabetes	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____
Macular Degeneration	Yes/No	Relation _____	Crossed Eye	Yes/No	Relation _____
Retinal Detachment	Yes/No	Relation _____	Lupus	Yes/No	Relation _____

**Social History:** Check  if you would prefer to discuss this portion with the doctor.

Do you use tobacco products? Yes/No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol? Yes/No If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs? Yes/No If yes, type/amount/how long: \_\_\_\_\_

Check if exposed to/infected with:  herpes  gonorrhea  hepatitis  HIV  Syphilis  TB

**Doctor Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_**