MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____
Date of birth: _____ E-mail address_____
Date of last eye exam: _____ Location of last eye exam: _____
Name of Family MD_____ Date of last visit to MD_____
List any medications you currently take (prescription and over-the-counter) or we can copy a list if you have one: _____
_____
_____
_____
Are you allergic to latex? YES NO
Do you have allergies to any medication? YES NO
If YES, list the medications: _____
List all major illnesses (glaucoma, diabetes, high blood pressure, etc.) Or injuries (concussion, etc.):
_____
_____
List any surgeries you have had (cataract, tonsillectomy, appendectomy) in the past five years:
_____
List any accidents, injuries, or operations to the eye in the last year_____

PLEASE MARK EVERY QUESTION BELOW WITH A YES OR A NO.
Do you currently have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES: Glaucoma, cataract, retinal disease or detachment, Macular Degeneration, Blindness Diabetic Retinopathy, etc.			
Floaters or Flashes of light			
Loss of Vision			
Blurred Vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/Light sensitivity			
Eye pain or soreness			
Infection of eye or eyelid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
Headaches			
ALLERGIES: Food, Seasonal, Animal Dander Environmental, etc.			
CARDIOVASCULAR: Heart Disease, High Blood Pressure, High Cholesterol, Pacemaker			
CONSTITUTIONAL: Weight gain/ loss, Blackouts, Nausea, Sleep Disorders, etc.			
EAR/NOSE & THROAT: Dry mouth, Hearing Loss, Sinusitis, Rhinitis, Chronic Cough, etc			
ENDOCRINE: Crohns Disease, Diabetes, Thyroid Disease, etc.			

CONTINUED ON OTHER SIDE

GASTROINTESTINAL: Acid Reflux, Colitis, Inflammatory Bowel, Ulcers, etc.			
GENITOURINARY: Menopause, Prostate Disorders, Bladder Disorders, etc.			
HEMATOLOGIC/LYMPHATIC: Anemia, Hodgkin's Disease, Leukemia, etc.			
IMMUNOLOGIC: Aids, HIV, Lyme Disease, Sjogrens, etc.			
INTEGUMENTARY (SKIN): Acne, Dermatitis, Psoriasis, Lupus, Shingles, etc.			
MUSCOSKELATAL: Arthritis, Muscular Dystrophy, Osteoporosis, etc.			
NEUROLOGICAL: Bells palsy, Epilepsy, Migraines, Muscular Sclerosis, Parkinson's, Neuropathy, etc.			
PSYCHIATRIC: Bi polar disorder, Depression, Insomnia, Alzheimer's, Anxiety, etc.			
RESPIRATORY: Asthma, Lung Disease or Cancer, Emphysema, COPD, etc.			

FAMILY HISTORY Disease	YES	NO	RELATIONSHIP M=mother F=father S=sister B=brother If Grandparent, please indicate grandmother or grandfather including paternal or maternal **If "YES", please include explanation**
Blindness			
Glaucoma			
Color Blindness			
Cataracts			
Macular Degeneration			
Cancer			(Type of cancer)
Diabetes			
Heart disease and/or High blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid Disease			
Arthritis			

SOCIAL HISTORY

Current occupation: _____Place of employment_____
Hobbies_____
Marital status: _____ Spouses Name: _____

Do you drive?	YES	NO
Do you have visual difficulty while driving?	YES	NO
Do you have problems with night vision?	YES	NO
Do you use a computer?	YES	NO
If YES, how many hours a day?	_____	
Have you ever tried to wear contact lenses?	YES	NO
If YES, how long have you worn contact lenses?	_____	
Do you currently wear glasses?	YES	NO
If YES, how long have you had the current prescription?	_____	
Do you drink alcohol?	YES	NO
Do you smoke?	YES	NO
Have you ever had a blood transfusion?	YES	NO
Are you pregnant or nursing?	YES	NO

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