

# Medical History Questionnaire

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Last medical exam \_\_\_\_\_ Last eye exam \_\_\_\_\_  
Medical Doctor (name, address, phone) \_\_\_\_\_ Pharmacy (name and phone) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Past Eye History (circle Y or N or ?)

Have YOU ever had:				Explain
Crossed Eyes	Y	N	?	_____
Lazy Eyes	Y	N	?	_____
Drooping Eyelid	Y	N	?	_____
Prominent Eyes	Y	N	?	_____
Glaucoma	Y	N	?	_____
Macular Degeneration	Y	N	?	_____
Retinal Detachment/ Disease	Y	N	?	_____
Cataracts	Y	N	?	_____
Eye Infections	Y	N	?	_____
Eye Injury	Y	N	?	_____
Eye Surgery	Y	N	?	_____
Loss of Vision/Side Vision	Y	N	?	_____
Dry Eyes	Y	N	?	_____
Itching	Y	N	?	_____
Double Vision	Y	N	?	_____
Blurred Vision	Y	N	?	_____
Flashes/Floaters	Y	N	?	_____

Any other eye problems not mentioned above? \_\_\_\_\_

Do you wear glasses? Y / N If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses? Y / N If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses: Rigid or Soft Wearing Schedule: Remove daily or sleep in lenses

How often do you throw away your lenses? \_\_\_\_\_ Are your lenses comfortable? Y / N

List any eye drops you use: \_\_\_\_\_

## Past Medical History

List any medicines YOU take (including oral contraceptives, aspirin, over the counter medications and home remedies): \_\_\_\_\_

\_\_\_\_\_

List any allergies to any medications and explain: \_\_\_\_\_

List all major injuries, surgeries and / or hospitalizations you have had: \_\_\_\_\_

\_\_\_\_\_

Are you pregnant or nursing? Y / N

List any medical problems/ diagnoses you have had (i.e. high blood pressure, diabetes, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Family History

Please note any family history (blood relatives – parents, grandparents, siblings and/or children, living or deceased)

for the following medical condition:

Disease/Condition				Relationship To You
Blindness	Y	N	?	_____

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**Family History (Continued)**

Disease/Condition				Relationship To You
Cataracts	Y	N	?	_____
Crossed Eyes	Y	N	?	_____
Glaucoma	Y	N	?	_____
Macular Degeneration	Y	N	?	_____
Retinal Detachment/Disease	Y	N	?	_____
Arthritis	Y	N	?	_____
Cancer	Y	N	?	_____
Diabetes	Y	N	?	_____
Heart Disease	Y	N	?	_____
High Blood Pressure	Y	N	?	_____
Kidney Disease	Y	N	?	_____
Lupus	Y	N	?	_____
Thyroid Disease	Y	N	?	_____
Other? _____				_____

**Social History**

Occupation \_\_\_\_\_ Marital Status S M D W  
 Do you drive? Y / N If yes, do you have visual difficulty when driving? Y / N If yes, please describe: \_\_\_\_\_  
 Do you use tobacco products? Y / N If yes, type/amount/how long: \_\_\_\_\_  
 Do you drink alcohol? Y / N If yes, type/amount/how long: \_\_\_\_\_  
 Do you use any other drugs? Y / N If yes, type/amount/how long: \_\_\_\_\_  
 Circle if you have ever been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis

**Review of Systems**

Do you currently, or have you ever had any problems in the following areas: (If yes, please explain and list medications)  
 Explanation/Medications

<b>General/Constitutional</b>			
Sudden Weight Gain	Y	N	?
Unexplained Weight Loss	Y	N	?
Other? _____			
<b>Integumentary ( Skin)</b>	Y	N	?
<b>Neurologic</b>			
Headaches/Migraines	Y	N	?
Seizures	Y	N	?
Multiple Sclerosis	Y	N	?
Other? _____			
<b>Eyes</b>			
Problem/Condition not listed?	Y	N	?
<b>Ear, Nose, Mouth, Throat</b>			
Sinus Congestion	Y	N	?
Dry Throat/Mouth	Y	N	?
Other? _____			
<b>Respiratory</b>			
Asthma	Y	N	?
Chronic Bronchitis	Y	N	?
Emphysema	Y	N	?
Other? _____			
<b>Vascular</b>			
Heart Attack	Y	N	?
Heart Disease	Y	N	?
Stroke	Y	N	?
Heart Pain/Angina	Y	N	?

**\*Please continue on page 3\***

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**Name** \_\_\_\_\_

**Review of Systems (continued)**

**Explanation/Medications**

**Vascular**

High Blood Pressure            Y   N   ?  
Vascular Disease                Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Gastrointestinal (Stomach/Intestines)**

Ulcer                                Y   N   ?  
Esophageal Reflux                Y   N   ?  
Digestive Disorder                Y   N   ?  
Cirrhosis                            Y   N   ?  
Hepatitis                            Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Genitourinary (Genitals, Kidney, Bladder)**

Kidney Disorder                 Y   N   ?  
Urinary Disorder                 Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Bones / Joints/ Muscles**

Rheumatoid Arthritis            Y   N   ?  
Osteoarthritis                    Y   N   ?  
Myasthenia Gravis                Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lymphatic / Hematologic (Blood)**

Anemia                                Y   N   ?  
High Cholesterol                 Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Endocrine (Glands)**

Thyroid                                Y   N   ?  
Diabetes                                Y   N   ?  
(How long/how controlled)  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Psychiatric**

Depression                         Y   N   ?  
Anxiety                                Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergic/Immunologic**

Allergies                                Y   N   ?  
Hay Fever                            Y   N   ?  
Lupus                                    Y   N   ?  
Sarcoidosis                         Y   N   ?  
Sjogrens                                Y   N   ?  
Other ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other**

Cancer                                 Y   N   ?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date Reviewed

