MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____ Date _____

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

_____

_____

Do you have any allergies? (Medications or other) YES NO
If yes, please list _____

List all major illnesses (Glaucoma, Diabetes, High blood pressure, Heart disease, COPD, etc.) or Injuries (concussion, etc.)

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, heart stents, heart bypass, etc)

_____

Do you currently have any problems in the following areas?

	YES	NO
EYES		
Loss of vision		
Blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Glare or light sensitivity		
Loss of side vision		
Double vision		
Dryness		
Mucous discharge		
Redness		
Sandy or gritty feeling		
Itching		
Burning		
Foreign body sensation		
Excess tearing or watering		
Eye pain or soreness		
Infection of eye or lids		
Tired eyes		
Crossed eyes/lazy eye		
Drooping eyelid		
General/Constitutional Fever, weight loss, other		
Ear, Nose, Throat Stuffy nose, ear ache, cough, dry mouth, etc.		
Cardiovascular High BP, racing pulse, etc.		
Respiratory Congestion, wheezing, etc.		
Gastrointestinal Upset stomach, diarrhea, Constipation, etc.		
Genital/Kidney/Bladder Painful urination, frequent urination, Impotence, etc.		
Muscles/Bones/Joints Joint pain, stiffness, swelling, Cramps, etc.		
Skin Pimples, warts, growths, rash, etc.		
Neurologic Numbness, headaches, etc.		
Psychiatric Anxiety, depression, insomnia		
Endocrine Diabetes, hypo/hyper thyroid, etc.		
Blood/Lymph High cholesterol, anemia, etc		
Allergic/Immunologic Sneezing, swelling, redness, itching, Hives, etc.		

To better help your doctor diagnose and treat your particular visual difficulties, please check all those that apply:

I wear or have worn:

__ No vision correction __ Glasses for distance
__ Glasses for near work __ Contact lenses

It is difficult to – (even while wearing my contacts or glasses)

__ read newspapers/books __ watch television __ sew
__see steps/curbs __ drive during the day __ drive at night
__ read traffic signs __do computer work
__ enjoy recreational activities __ other difficulties

I currently have problems with:

__ glare __ halos around lights __ blurred vision __ hazy vision
__ headaches __seeing in dim light __poor night vision
__ tired eyes

FAMILY AND SOCIAL HISTORY

Family History

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

Disease	Yes	No	Relationship to patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

Social History

Current Occupation _____

Education (high school, vocational school, college degree) _____

Do you drive? YES NO
Do you have visual difficulty when driving? YES NO
Do you have problems with night vision? YES NO

Do you currently wear contact lenses? YES NO If yes, what brand? _____

Do you currently wear glasses YES NO If yes, how long have you had your current prescription? _____

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If yes: occasional 1/day 2-3/day 4+/day

Do you smoke? Cigarettes – cigar – pipe YES NO If yes: occasional ½ pack/day 1 pack/day 1+ pack/ day