MEDICAL HISTORY QUESTIONNAIRE

PATIENT LEGAL NAME: ____

SSN: ___________________________ SEX: ☐M ☐F DOB: ______________

Date of most recent eye exam: ________ month ________ day ________ year

List any medications, prescription and over-the-counter, you are currently taking:

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List any medications to which you are allergic: __________________________

List any surgeries you have undergone: ______________________________

Have you or are you currently experiencing any problems with the following:

DISEASE OR CONDITION	Y	N	If yes, please describe.
VISION			
Glaucoma, cataract, retinal disease, etc.			
Loss of vision			
Blurred or fluctuating vision			
Loss of peripheral vision			
Distorted vision (halos) or double vision			
Dryness, itchiness, or sandy, gritty feeling			
Mucous discharge			
Redness or burning			
Foreign body sensation			
Excess tearing/watering			
Glare, sensitivity to light			
Soreness or pain			
Infection of eye or lid (Blepharitis, stye, etc.)			
Tired eyes			
Crossed or lazy eye (Strabismus)			
Drooping eyelid			
Other			
GENERAL / CONSTITUTIONAL (Fever, weigh loss or gain, etc.)			
EARS / NOSE / THROAT (Sinus/ear infection, chronic cough, dry mouth, etc.)			
CANCER			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emplysema, etc.)			
GASTROINTESTINAL (Stomach ulcer, intestinal disease, etc.)			
GENITAL / KIDNEY / BLADDER			
MUSCLES / BONES / JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			

PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (Cholesterolemia, anaemia, etc.)			
ALLERGIES / IMMUNOLOGIC (Hay fever, lupus, Sjogren's Syndrome, etc.)			

Family History

(Please indicate relationship: F = Father M = Mother S = Sibling GP = Grandparent)

DISEASE OR CONDITION	Y	N	EXPLAIN / RELATIONSHIP TO PATIENT
Blindness, glaucoma, cataract			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Renal disease			
Lupus			
Heart attack or stroke			
Thyroid Disease			
Other			

Social History

Current Occupation: ____

Education (High school, vocational school, university): ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

Living arrangements: ☐ Live alone ☐ Live with parent ☐ Roommate(s)s

Do you drive? ☐ YES ☐ NO

Do you have vision difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If so, how long have you had your current prescription? ____________________

Do you currently wear glasses? ☐ YES ☐ NO

If so, how long have you had your current prescription? ____________________

Do you drink alcohol? ☐ Never ☐ Rarely/Socially ☐ Occasionally ☐ Often

Do you smoke? ☐ Never ☐ Rarely/Socially ☐ Occasionally ☐ Often

Have you ever had a blood transfusion? ☐ YES ☐ NO

Please include any other information you feel may be relevant: _______________

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