MEDICAL HISTORY QUESTIONNAIRE

Name ______________________________________ Date ________________________________
Date of birth ___________________________ Date of last eye exam _____________________
Name of medical doctor __________________________________ Pharmacy _________________
List any medications you are currently taking (prescription and over the counter)
____
____
Do you have any food or drug allergies? □ Yes □ No _____________________________________
List all major injuries and surgeries you have had ____
____
Do you wear glasses? □ No □ Yes Do you wear contact lenses? □ No □ Yes
If yes, how old are your present pair of lenses? ____________________________

FAMILY HISTORY

Has any member of your family (parents, grandparents, siblings) had any of the following diseases?

Blindness	□ No	□ Yes	Cataract	□ No	□ Yes	Crossed Eyes	□ No	□ Yes
Glaucoma	□ No	□ Yes	Diabetes	□ No	□ Yes	Retina Maculae Disease	□ No	□ Yes
Cancer	□ No	□ Yes	Heart Disease	□ No	□ Yes	Hypertension	□ No	□ Yes

REVIEW OF SYSTEMS **Do you have any of the following problems?** **Please circle**

Blurred vision, double vision, distorted vision, flashes/floaters in vision, halos
Mucous discharge, dryness, glare/light sensitivity, tired eyes
Itching, burning, excess tearing/watering, redness
Eye pain, soreness, foreign body sensation, bumps on lids
Chronic fever, unexpected weight loss/gain, fatigue
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)
Heart problems (chest pain, irregular heart beat)
High blood pressure
Respiratory problems (shortness of breath, wheezing, coughing)
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)
Kidney/urinal problems (pain or discomfort, blood in urine)
Skin problems (rashes, excessive dryness)
Musculoskeletal problems (muscle aches, joint pain, swollen joints)
Neurologic problems (numbness, weakness, headaches, paralysis, seizures)
Psychiatric problems (depression, anxiety)
Diabetes or thyroid problems
Anemic or bleeding problems
Allergic/immunological (sneezing, swelling, redness, itching, hives, etc)
Lupus

Females Are you pregnant and/or nursing □ No □ Yes

Do you drive? □ No □ Yes
Do you use tobacco? □ No □ Yes If yes, how much ____________________________
Do you drink alcohol? □ No □ Yes If yes, how much? ___________________________

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Doctor's signature Date