MEDICAL HISTORY QUESTIONNAIRE

Name:_____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: _____

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEMS
Eyes			
Loss or blurred vision	[ ]	[ ]	_____
Loss of side vision, double vision	[ ]	[ ]	_____
Itching, burning, or discharge	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Gritty feeling, dryness or tearing	[ ]	[ ]	_____
Glare/light sensitivity, or halos	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular, (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)	[ ]	[ ]	_____
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/breast)	[ ]	[ ]	_____
Neurological	[ ]	[ ]	_____
Psychiatric	[ ]	[ ]	_____
Endocrine (hormones, glands)	[ ]	[ ]	_____
Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	

_____

_____

_____

_____

Allergies to eye drops	[ ]	[ ]	List drops you are allergic to: _____
History of cataract, glaucoma	[ ]	[ ]	_____
History of cross/lazy eye	[ ]	[ ]	_____
Eye injury or other disease	[ ]	[ ]	_____
Eye surgery	[ ]	[ ]	_____

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: _____

_____

_____

List all major illnesses: Diabetes _____ Hypertension _____

Other: _____

_____

List any major surgical procedures: _____

_____

Do you have any medication allergies: [ ] NO [ ] YES Penicillin Sulfa

List other medication allergies:_____

_____

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCCULAR			
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____
MEDICAL			
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____
Other (list)	[ ]	[ ]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCCULAR			
Have you ever tried to wear contacts?	[ ]	[ ]	_____
Did you have problems with contacts?	[ ]	[ ]	_____
Vision causes problems with:			
❑ Driving ❑ Night vision ❑ Reading ❑ Sports/Outdoor activties			
GENERAL			
Do you drink alcohol?	[ ]	[ ]	How much per day? _____
Do you smoke?	[ ]	[ ]	
Have you ever had a blood transfusion?	[ ]	[ ]	
Have you ever had contact with a person who had a sexually transmitted disease?	[ ]	[ ]	

Patient's signature: _____ Date: _____

History reviewed [ ] No changes [ ] Additions as noted

Physician's signature: _____ Date: _____