Medical History Questionnaire

This form is critical for the doctor to thoroughly evaluate your vision and health.
Please completely fill out both pages. Thank you!

Name: ___________________________ Date: __________________ Birth date: _____________

Last Medical Exam:_____________ Last Eye Exam: __________ Age: ______

Name of Family Physician: __________________________

Personal Medical History

List ***all medications*** you are currently taking (i.e. oral contraceptives, aspirin):

____

Do you have any ***allergies*** **or** ***allergies to medications***? **Y / N** If yes, please explain:

____

List any ***injuries/surgeries*** you have had and when? __________________________________

Do you have a history of any ***eye diseases/conditions***? **Y / N** If yes, please describe:

____

Do you wear ***glasses*** **or** ***contact lenses***? **Y / N** If yes, which do you wear and how old is the current pair? ____

Family Medical History

Please list the family member(s) with the following medical conditions:

Disease/Condition		**Family member (i.e. mother, paternal grandfather,etc)**
1. Blindness	Y / N	_______________________
2. Lazy Eyes	Y / N	_______________________
3. Glaucoma	Y / N	_______________________
4. Macular disease	Y / N	_______________________
5. Retinal Disease	Y / N	_______________________
6. Arthritis	Y / N	_______________________
7. Diabetes	Y / N	_______________________
8. Hypertension	Y / N	_______________________
9. Heart Disease	Y / N	_______________________
10. Thyroid Disease	Y / N	_______________________
11. OTHER:		_______________________

Social History

Do you currently ***Drive***? **Y / N** If yes, Do you have visual difficulties driving? **Y / N**
Please Explain: ____
Do you ***smoke***? **Y / N** If yes, how long have you smoked for? _________ years
Do you ***drink alcohol***? **Y / N** If yes, how often and how long? _____________
Do you use **controlled substances**? **Y / N** If yes, please explain: _____________
Do you have a history of any ***venereal diseases***? **Y / N** If yes, what kind?

____

Review of Systems: Please circle. If you answer yes, please explain.

System	Yes or No	Not sure	Explain/Medications
I. Integumentary (skin)	Y / N	?	______
II. Neurologic			
1. Headaches/Migraine	Y / N	?	______
2. Seizures	Y / N	?	______
III. Eyes			
1. Loss of Vision	Y / N	?	______
2. Double Vision	Y / N	?	______
3. "Pink"/ Red Eye	Y / N	?	______
4. Light Sensitive	Y / N	?	______
5. Eye Pain	Y / N	?	______
6. Eye infections	Y / N	?	______
7. Eye Diseases	Y / N	?	______
8. Watery Eyes	Y / N	?	______
9. Dry Eyes	Y / N	?	______
IV. Ears, Nose, Mouth, Throat			
1. Allergies	Y / N	?	______
2. Hay Fever	Y / N	?	______
3. Sinus Congestion	Y / N	?	______
4. Runny Nose	Y / N	?	______
5. Dry Throat/Mouth	Y / N	?	______
6. Ear Infection	Y / N	?	______
V. Respiratory			
1. Asthma	Y / N	?	______
2. Chronic Bronchitis	Y / N	?	______
3. Emphysema	Y / N	?	______
VI. Vascular			
1. Diabetes	Y / N	?	______
2. High Blood Pressure	Y / N	?	______
3. Vascular Disease	Y / N	?	______
VII. Gastrointestinal			
1. Diarrhea	Y / N	?	______
2. Constipation	Y / N	?	______
VIII. Genitourinary			
1. Genitals	Y / N	?	______
2. Kidney/Bladder	Y / N	?	______
IX. Bones/Joints/Muscles			
1. Rheumatoid Arthritis	Y / N	?	______
2. Muscle/joint Pain	Y / N	?	______
X. Lymphatic/Hematological			
1. Anemia	Y / N	?	______
2. Bleeding Problems	Y / N	?	______
XI. Endocrine			
1. Thyroid/other	Y / N	?	______
XII. Psychiatric			
1. Anxiety/ depression	Y / N	?	______
XIII. Constitutional			
1. Fever	Y / N	?	______

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