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. 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	?	_____
II. Vascular			
1. Diabetes	Y / N	?	_____
2. High Blood Pressure	Y / N	?	_____
3. Vascular Disease	Y / N	?	_____
III. Constitutional			
1. Fever	Y / N	?	_____
IV. Endocrine			
1. Thyroid/other	Y / N	?	_____
V. Gastrointestinal			
1. Diarrhea	Y / N	?	_____
2. Constipation	Y / N	?	_____
VI. Genitourinary			
1. Genitals	Y / N	?	_____
2. Kidney/Bladder	Y / N	?	_____
VII. 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	?	_____
VIII. Lymphatic/Hematological			
1. Anemia	Y / N	?	_____
2. Bleeding Problems	Y / N	?	_____
IX. Integumentary (skin)	Y / N	?	_____
X. Bones/Joints/Muscles			
1. Rheumatoid Arthritis	Y / N	?	_____
2. Muscle/joint Pain	Y / N	?	_____
XI. Neurologic			
1. Headaches/Migraine	Y / N	?	_____
2. Seizures	Y / N	?	_____
XII. Psychiatric			
1. Anxiety/ depression	Y / N	?	_____
XIII. Respiratory			
1. Asthma	Y / N	?	_____
2. Chronic Bronchitis	Y / N	?	_____
3. Emphysema	Y / N	?	_____