Name:_____ Date:_____

Email:_____ **Medical History Questionnaire** Birth Date:___/___/___

Last Eye Exam____/____ Last Eye Dr.:_____ Last Medical Exam____/____ Current Medical Dr._____

Women only: Are you pregnant? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N Do or did you have gestational diabetes? ☐ Y ☐ N

Do you have any allergies to medications? ☐ Y ☐ N If yes, explain_____

List any medications you take (including oral contraceptives, aspirin, OTC medications and home remedies):

_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

Please circle any of the following **you** have/had:

Ocular: Glaucoma, Cataracts, Macular Degeneration

Blindness, Crossed Eyes, Other: _____

Medical: Diabetes, Hypertension, Cancer, Heart Disease,

Other_____

Please circle any of the following your **family** members have/had:

Ocular: Glaucoma, Cataracts, Macular Degeneration

Blindness, Crossed Eyes, Other: _____

Medical: Diabetes, Hypertension, Cancer, Heart Disease,

Other_____

Height_____ Weight_____

Social History

If you would prefer to discuss your Social History directly with the doctor please check box: ☐

Do you drive? ☐ Y ☐ N If yes, do you have visual difficulty when driving? ☐ Y ☐ N If yes, explain_____

_____

Do you use tobacco products? ☐ Y ☐ N If yes, type/amount/how long:_____

Do you drink alcohol? ☐ Y ☐ N If yes, type/amount/how long:_____

Do you use illegal drugs? ☐ Y ☐ N If yes, type/amount/how long:_____

If you have ever been exposed to or infected with any of the following please circle: gonorrhea, hepatitis, HIV, Syphilis

Review of Systems: Do you currently or have you ever had any problems in the following areas:

Allergic/Immunologic
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Lupus
☐ Other_____

Cardiovascular
☐ Y ☐ N Diabetes
☐ Y ☐ N Heart Pain
☐ Y ☐ N Hypertension
☐ Y ☐ N Vascular Disease
☐ Other_____

Constitutional
☐ Y ☐ N Fever (Recent)
☐ Y ☐ N Weight Loss/Gain (Recent)
☐ Y ☐ N Trauma
☐ Other_____

Ears, Nose, Mouth, Throat
☐ Y ☐ N Allergies/Hay Fever
☐ Y ☐ N Sinus Congestion
☐ Y ☐ N Runny Nose
☐ Y ☐ N Post-Nasal Drip
☐ Y ☐ N Chronic Cough
☐ Y ☐ N Dry Throat/Mouth
☐ Other_____

Endocrine
☐ Y ☐ N Thyroid
☐ Other glands_____

Eyes
☐ Y ☐ N Loss of vision
☐ Y ☐ N Distorted vision/Halos
☐ Y ☐ N Loss of Side Vision
☐ Y ☐ N Dryness
☐ Y ☐ N Redness
☐ Y ☐ N Sandy/Gritty Feeling
☐ Y ☐ N Itching/ Burning
☐ Y ☐ N Foreign Body Sensation
☐ Y ☐ N Glare/Light Sensitivity
☐ Y ☐ N Eye pain/ Soreness
☐ Y ☐ N Chronic Infection of Eye or Lid
☐ Y ☐ N Tired Eyes
☐ Other_____

Gastrointestinal
☐ Y ☐ N Diarrhea/Constipation
☐ Y ☐ N Crohn's
☐ Y ☐ N Ulcer
☐ Other_____

Genitourinary
☐ Y ☐ N Genitals/Kidney/Bladder
☐ Y ☐ N STD-viral herpetic, chlamydia
☐ Other_____

Hematologic/Lymphatic
☐ Y ☐ N Anemia
☐ Other_____

Integumentary (Skin)
☐ Y ☐ N Eczema
☐ Y ☐ N Rosacea
☐ Other_____

Muskuloskeletal
☐ Y ☐ N Rheumatoid Arthritis
☐ Y ☐ N Muscle Pain
☐ Y ☐ N Joint Pain
☐ Other_____

Neurological
☐ Y ☐ N Multiple sclerosis
☐ Y ☐ N Epilepsy
☐ Other_____

Psychiatric
☐ Y ☐ N Depression
☐ Y ☐ N Panic disorder
☐ Y ☐ N Schizophrenia
☐ Other_____

Respiratory
☐ Y ☐ N Asthma
☐ Y ☐ N Bronchitis
☐ Y ☐ N Emphysema
☐ Other_____

Doctor's Comments _____

_____

I have reviewed this history with the patient: _____Date:_____