

MEDICAL HISTORY QUESTIONNAIRE

Date _____

Name _____ Date of Birth _____ Date of last exam _____

Please circle all that apply and explain in space provided below.

Eyes: Loss of vision	Blurred vision	Fluctuating vision	Distorted vision	Halos	Redness
Loss of side vision	Double vision	Dryness	Mucous discharge	Itching	Excess
tearing/watering	Sandy or gritty feeling	Burning	Foreign body sensation	Drooping eyelid	
Crossed eyes/lazy eye	Glare/light sensitivity	Eye pain or soreness	Infection of eye or lid	Tired eyes	
Night vision difficulty	Visual difficulty when driving		Problems with night driving		

Do you now or have you had any of these eye problems: Blindness Cataracts Detached Retina Macular Degeneration Injury Other

Do you: Wear glasses? Yes _____ No _____ Smoke? Yes _____ No _____ Drink alcohol? Yes _____ No _____

Women, are you: Currently pregnant or nursing? Yes _____ No _____ Drug use? Yes _____ No _____

Have you ever: Tried contact lenses? Yes _____ No _____ Had a blood transfusion? Yes _____ No _____

List any **medications** you currently take none _____

List any **allergies** to medications none _____

List any **surgeries** you have had none _____

List all major illnesses or injuries:

General/Constitutional (fever, weight loss, other) none _____

Ear, Nose, Throat (sinus, ear infection, chronic cough, dry mouth) none _____

Cardiovascular (heart, vessels) none _____

Respiratory (asthma, emphysema, etc.) none _____

Gastrointestinal (stomach ulcers, intestinal disease) none _____

Genital/Kidney/Bladder none _____

Muscles/Bones/Joints (arthritis, etc.) none _____

Skin (acne, warts, skin cancer, etc.) none _____

Neurological (multiple sclerosis, etc.) none _____

Psychiatric (anxiety, depression, insomnia, etc.) none _____

Endocrine (diabetes, thyroid disease, etc.) none _____

Blood/Lymph (high cholesterol, anemia, etc.) none _____

Allergy/Immunology (hayfever, lupus, etc.) none _____

Have you ever had an unusual infection that was difficult to treat with antibiotics? none _____

Family History Disease (please give details and relationship to patient)

Arthritis	Cancer	Diabetes	Heart Disease or High Blood Pressure	Kidney Disease	Lupus	Stroke
Thyroid Disease	Blindness	Cataracts	Detached Retina	Glaucoma	Macular Degeneration	Other

Reviewing Doctor Signature _____

Updated date _____	Patient Initials _____	Tech Initials _____	Dr. Initials _____
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