MEDICAL HISTORY QUESTIONNAIRE

Please complete both sides of this form completely and accurately.

Date: ______________________

Patient: ______________________ Date of Birth: ______________________

Please list the following:

1) All reasons for your visit today: ______________________

2) All medications that you currently are taking (prescription and over-the-counter): ______________________

3: All eye drops/ointments that you use (prescription and over-the-counter): ______________________

4) All major illnesses (ex. eye diseases, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): ______________________

5) Any eye surgeries that you have had with dates & which eye (ex. laser, cataract): ______________________

6) Any other surgeries: ______________________

7) Do you experience headaches? ☐N ☐Y If yes, how often? ______________________

8) Do you have allergies to any medications? ☐N ☐Y If so, list the medications: ______________________

PAST HISTORY

Date of Last Eye Exam: ______________ Location/Dr. ______________

Prior or current glasses wearer? ☐N ☐Y If yes, explain use and satisfaction level: ______________

Prior or current contact lens wearer? ☐N ☐Y If yes, explain use and satisfaction level: ______________

Are you a computer user? ☐N ☐Y If yes, how many hours per day? ______________

If you are a female, are you pregnant or nursing? ☐N ☐Y

Have you ever had any trauma to the eye? ☐N ☐Y If yes, please explain: ______________

Have you ever been diagnosed with cancer? ☐N ☐Y If yes, please explain: ______________

FAMILY HISTORY

Disease / Condition				Relationship to You
Blindness	☐N	☐Y	☐?	______________
Cataracts	☐N	☐Y	☐?	______________
Crossed Eyes	☐N	☐Y	☐?	______________
Glaucoma	☐N	☐Y	☐?	______________
Macular Degeneration	☐N	☐Y	☐?	______________
Retinal Detachment	☐N	☐Y	☐?	______________
Cancer	☐N	☐Y	☐?	______________
Diabetes	☐N	☐Y	☐?	______________
Heart Disease	☐N	☐Y	☐?	______________
High Blood Pres.	☐N	☐Y	☐?	______________
Lazy Eye	☐N	☐Y	☐?	______________

SOCIAL HISTORY

This information is strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would like to discuss my Social History information directly with my doctor. (Check box)

Do you have vision problems while driving? ☐ No ☐ Yes If yes, please describe: ______________

Do you use tobacco? ☐ No ☐ Yes If yes, type/amount/how long: ______________

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ______________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long: ______________

Review of Health Systems

Please check YES or NO if you have a health problem in each of these health categories.

Ocular Conditions ☐ No ☐ Yes
- ☐ Glaucoma
- ☐ Cataract
- ☐ Corneal
- ☐ Macular Degen.
- ☐ *Retinal Detach.*
- ☐ Ret. Pigmentosa
- ☐ Other

Ears/Nose/Mouth/Throat ☐ No ☐ Yes
- ☐ Sinus Infection
- ☐ Hearing Problems
- ☐ Vertigo
- ☐ Other

Hematologic/Lymphatic ☐ No ☐ Yes
- ☐ Anemia
- ☐ Large vol. blood loss
- ☐ Leukemia
- ☐ Other

Gastrointestinal ☐ No ☐ Yes
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer / Digestive
- ☐ Kidneys / Kid. Stones
- ☐ Other

Musculoskeletal ☐ No ☐ Yes
- ☐ Fibromyalgia
- ☐ Musc. Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylo. Spondylitis
- ☐ Sjogrens
- ☐ Other

Allergy/Immune ☐ No ☐ Yes
- ☐ Drug allergy
- ☐ Environ. allergy
- ☐ Rheum. arthritis
- ☐ Lupus
- ☐ Other

Cardiovascular ☐ No ☐ Yes
- ☐ Heart Disease
- ☐ *Hypertension*
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Vascular Disease

Constitutional ☐ No ☐ Yes
- ☐ Develop. disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other

Genitourinary ☐ No ☐ Yes
- ☐ Sex. Trans. Dis.
- ☐ Bladder Infect.
- ☐ Prostate
- ☐ Other

Psychiatric ☐ No ☐ Yes
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other

Integumentary ☐ No ☐ Yes
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other

Respiratory ☐ No ☐ Yes
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

Endocrine ☐ No ☐ Yes
- ☐ *Insulin-dep. diab.*
- ☐ *Non-insulin dep. diab.*
- ☐ Thyroid dysf.
- ☐ Hormonal dysf.
- ☐ Other

Neurological ☐ No ☐ Yes
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other

Ocular Review

Please check YES or NO if you have any of the listed eye problems. If YES, please provide the following details:
Which Eye / For How Long / Severity / Any Treatment / Other Details

Blurred Vision	☐ NO	☐ YES: ______
Flashes of Light	☐ NO	☐ YES: ______
Floaters	☐ NO	☐ YES: ______
Cobwebs	☐ NO	☐ YES: ______
Fluctuating Vision	☐ NO	☐ YES: ______
Distorted Vision (halos)	☐ NO	☐ YES: ______
Loss of Side Vision	☐ NO	☐ YES: ______
Blindspots	☐ NO	☐ YES: ______
Double Vision	☐ NO	☐ YES: ______
Dryness	☐ NO	☐ YES: ______
Mucous Discharge	☐ NO	☐ YES: ______
Redness	☐ NO	☐ YES: ______
Sandy or gritty feeling	☐ NO	☐ YES: ______
Itching or burning	☐ NO	☐ YES: ______
Problems with night vision	☐ NO	☐ YES: ______
Foreign body sensation	☐ NO	☐ YES: ______
Excess tearing/watering	☐ NO	☐ YES: ______
Glare/light sensitivity	☐ NO	☐ YES: ______
Eye pain or soreness	☐ NO	☐ YES: ______
Infection of eye or lid	☐ NO	☐ YES: ______
Tired eyes	☐ NO	☐ YES: ______
Crossed eyes / Lazy eye	☐ NO	☐ YES: ______
Drooping eyelid	☐ NO	☐ YES: ______

Reserved for doctor use.

☐ **Primary ROS taken today**

or

☐ **Reviewed previous ROS today from** ____/____/______

☐ Changes noted ☐ No changes

Doctor Signature: ______________________