MEDICAL HISTORY QUESTIONNAIRE

(office use only)
MR#:___________________

Date:___________Patient Name:________________________________

Date of Birth:________________Date of last eye exam:____

FamilyDoctor:___________________________________Referring Doctor:___________________________
Pharmacy :______________________________________Phone Number:___________________________
List any **medications (including eye medications)** you currently take (prescription/over-the-counter)
____
____
____
List any medical **allergies:**____
List previous **surgeries:**____
List any past eye injuries/trauma:____

Do you currently have any problems in the following areas? (If "yes, please provide information)

Disease	Yes	No	Explanation of the problem
EYES (glaucoma, cataract, etc.)			
Do you have any loss of vision, blurred vision, fluctuating vision)			
Double vision			
Mucous discharge			
Redness			
Sandy, gritty, foreign body sensation			
Itching or burning			
Excess tearing / watering			
Glare / Light sensitivity, halos			
Eye soreness or pain			
Infection or swelling			
Tired eyes			
Crossed eyes			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
SYSTEM REVIEW			
Ears, nose, throat (sinus, infections, etc.)			
Cardiovascular (heart, high blood pressure, heart disease, etc.)			
Respiratory (pneumonia, COPD, etc.)			
Gastrointestinal (ulcers, intestinal problems, etc.)			

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Disease con't.	Yes	No	Explanation of problem
Genital, kidney, bladder			
Muscles, bones, joints (arthritis, etc.)			
Skin (Acne, warts, skin cancer, etc)			
Neurological (MS, stroke, etc.)			
Psychiatric (anxiety, depression, etc.)			
Endocrine (diabetes, thyroid, etc.)			
Blood / Lymph (cholesterol, anemia, etc.)			
Allergic/Immunological (hay fever, lupus, etc.)			

FAMILY HISTORY M=Mother F-Father S=Sibling GP=Grandparent

Disease	Yes	No	Relationship to Patient
Any history of any eye conditions			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
Do you live alone? ☐ Yes ☐ No

Employment status: ☐ Retired ☐ Unemployed ☐ Employed
Current place of employment____

Do you drive? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
If yes, indicate how much: ☐ Occasional ☐ 1 time per day ☐ 2 – 3 times/day ☐ 4+ times/day
Do you smoke?
If yes, indicate how much: ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day
Have you ever had a blood transfusion? ☐ Yes ☐ No

Please list any hobbies you have:____

Patient Signature:____**Date:**__________________

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