

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of birth _____ Date of last eye exam _____

Current Medications, prescriptions and over-the-counter (include dose and how often): _____

Are you using any eye drops (occasional or daily)? N/A

Do you have allergies to any medications? YES NO

If YES, please list:

Have you ever been diagnosed with or treated for these following conditions? If yes, please check the box and write the date of first diagnosis or treatment if known.

- | | |
|--|---|
| <input type="checkbox"/> Heart disease/Murmur/Angina _____ | <input type="checkbox"/> Seasonal Allergies _____ |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heartburn/Acid Reflux _____ | <input type="checkbox"/> Neurological Problems _____ |
| <input type="checkbox"/> Low Blood Pressure _____ | <input type="checkbox"/> Depression/Anxiety _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Kidney/Bladder problems _____ |
| <input type="checkbox"/> Diabetes _____ Type: I or II | <input type="checkbox"/> Liver problems/Hepatitis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Osteoarthritis _____ |
| <input type="checkbox"/> Migraines/Headaches _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ |
| <input type="checkbox"/> Sinus problems _____ | <input type="checkbox"/> Cancer _____ |
| | <input type="checkbox"/> Thyroid problems _____ |

Please describe any current or past medical treatment not listed above and/or write specific details regarding above diagnoses (what type of cancer, heart disease, etc.): _____

Please list your past surgeries, including eye surgery/laser treatments (with date): _____

Do you currently have any problems in the following areas?

- | | |
|--|--|
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Glare/light sensitivity |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Eye pain/soreness |
| <input type="checkbox"/> Fluctuating/changing vision | <input type="checkbox"/> Infection of eye or lid |
| <input type="checkbox"/> Distorted vision/halos | <input type="checkbox"/> Tired eyes |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Crossed eyes, lazy eye |
| <input type="checkbox"/> Loss of side vision | <input type="checkbox"/> Drooping eyelid |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Mucous discharge | <input type="checkbox"/> Corneal abrasion |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Sandy/gritty feeling | <input type="checkbox"/> Eye injury |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Foreign body sensation | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Excess tearing/watering | <input type="checkbox"/> Retinal detachment |

Please check the box if you have a family history of these conditions. Write the relationship to the patient in the space provided (M=mother, F=father, S=sibling, GP=grandparent).

- | | |
|--|--|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Lupus _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> _____ |

Do you drive? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Have you ever tried to wear contact lenses? Yes No

Do you currently wear contact lenses? Yes No

How old is your current prescription? _____

Do you drink alcohol? Yes No

 If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke? Yes No

 If YES: occasional 1/2 pack/day 1 pack/day 1+pack/day