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.

□Heart disease/Murmur/Angina ______
□High Cholesterol ______
□High Blood Pressure ______
□Heartburn/Acid Reflux ______
□Low Blood Pressure ______
□Anemia ______
□Diabetes ______ Type: I or II
□Asthma ______
□Migraines/Headaches ______
□Sinus problems ______
□Seasonal Allergies ______
□Seizures ______
□Stroke ______
□Neurological Problems ______
□Depression/Anxiety ______
□Kidney/Bladder problems ______
□Liver problems/Hepatitis ______
□Osteoarthritis ______
□Rheumatoid Arthritis _____
□Cancer ______
□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?

□Loss of vision
□Blurred vision
□Fluctuating/changing vision
□Distorted vision/halos
□Double vision
□Loss of side vision
□Dryness
□Mucous discharge
□Redness
□Sandy/gritty feeling
□Itching
□Burning
□Foreign body sensation
□Excess tearing/watering
□Glare/light sensitivity
□Eye pain/soreness
□Infection of eye or lid
□Tired eyes
□Crossed eyes, lazy eye
□Drooping eyelid
□Cataracts
□Corneal abrasion
□Dry eyes
□Eye injury
□Glaucoma
□Iritis/Uveitis
□Macular degeneration
□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).

□Blindness ________
□Glaucoma ________
□Cancer ________
□Diabetes ________
□Heart disease ________
□High blood pressure ________
□Kidney disease ________
□Lupus ________
□Stroke ________
□________________________

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