

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: _____

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEMS
Eyes			
Loss or blurred vision	[]	[]	_____
Loss of side vision, double vision	[]	[]	_____
Itching, burning, or discharge	[]	[]	_____
Redness	[]	[]	_____
Gritty feeling, dryness or tearing	[]	[]	_____
Glare/light sensitivity, or halos	[]	[]	_____
Eye pain or soreness	[]	[]	_____
Infection of eye lashes or lid, styes	[]	[]	_____
Ears, nose, mouth, throat	[]	[]	_____
Cardiovascular, (heart, blood vessels)	[]	[]	_____
Respiratory (lungs/breathing)	[]	[]	_____
Gastrointestinal (stomach/intestines)	[]	[]	_____
Genitourinary (genitals/kidney/bladder)	[]	[]	_____
Musculoskeletal (muscles/joints)	[]	[]	_____
Integument (skin/breast)	[]	[]	_____
Neurological	[]	[]	_____
Psychiatric	[]	[]	_____
Endocrine (hormones, glands)	[]	[]	_____
Hematologic/Immunologic (blood)	[]	[]	_____
Seasonal allergies (hay fever, etc.)	[]	[]	_____

PAST HISTORY (EYE)

Eye drops currently in use: (list)	[]	[]
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Allergies to eye drops	[]	[]	List drops you are allergic to: _____
History of cataract, glaucoma	[]	[]	_____
History of cross/lazy eye	[]	[]	_____
Eye injury or other disease	[]	[]	_____
Eye surgery	[]	[]	_____

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: _____

List all major illnesses: Diabetes _____ Hypertension _____

Other: _____

List any major surgical procedures: _____

Do you have any medication allergies: [] NO [] YES Penicillin Sulfa

List other medication allergies: _____

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCCULAR			
Blindness	[]	[]	_____
Cataract	[]	[]	_____
Glaucoma	[]	[]	_____
Macular degeneration	[]	[]	_____
Retinal detachment	[]	[]	_____
MEDICAL			
Diabetes	[]	[]	_____
Arthritis, lupus, etc.	[]	[]	_____
Other (list)	[]	[]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCCULAR			
Have you ever tried to wear contacts?	[]	[]	_____
Did you have problems with contacts?	[]	[]	_____
Vision causes problems with:			
☐ Driving			
☐ Night vision			
☐ Reading			
☐ Sports/Outdoor activities			
GENERAL			
Do you drink alcohol?	[]	[]	How much per day? _____
Do you smoke?	[]	[]	
Have you ever had a blood transfusion?	[]	[]	
Have you ever had contact with a person who had a sexually transmitted disease?	[]	[]	

Patient's signature: _____ Date: _____

History reviewed [] No changes [] Additions as noted

Physician's signature: _____ Date: _____