Name _____ Medical Record _____

Date _____

MEDICAL HISTORY QUESTIONNAIRE

Reason for visit: _____

Who referred you to our practice: _____

Primary care physician and their location: _____

EYE SYMPTOMS (Do you currently have any of the following symptoms?)

	Yes	No		Yes	No
Blurred vison	☐	☐	Eye pain or soreness	☐	☐
Distorted vison	☐	☐	Dryness, burning	☐	☐
Loss of side vision	☐	☐	Grittiness, foreign body sensation	☐	☐
Double vision	☐	☐	Itching	☐	☐
Night vision problems, halos, glare	☐	☐	Redness	☐	☐
Light sensitivity	☐	☐	Discharge	☐	☐
Flashes of light	☐	☐	Tearing, watering	☐	☐
Floating spots in vision	☐	☐	Droopy or swollen eyelids	☐	☐

Explain any yes answers (which eye, duration, severity) _____

ALLERGIES

Do you have allergies to any medications? Yes ☐ No ☐ Do you have a latex sensitivity? Yes ☐ No ☐

If yes, list the medications _____

EYE, MEDICAL AND SURGICAL HISTORY

List all major illnesss _____

List any surgeries _____

MEDICATIONS

Please list all prescriptions and OTC medications: _____

Review of Systems	YES	NO	Details of any answered yes
Eyes (poor vision, eye pain, tearing, redness, etc.)			
General/Constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
Cardiovascular (high BP, racing pulse, etc.)			
Respiratory (congestion, wheezing, shortness of breath, etc.)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers etc.)			
Genital, Kidney, Bladder (painful urination,frequent urination, impotence, yellow jaundice, etc.)			
Females (Are you pregnant? Nursing?)			
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures,paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood/Lymph (bleeding, cholesterolemia, anemia problems, related to blood transfusions, etc.)			
Allergic, Immunologic (sneezing, swelling, redness, itching, hives,lupus, etc.)			

FAMILY HISTORY

Has any member of your family had these diseases? (circle all that apply) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Macular Degeneration

Other eye heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Do you drink alcohol? YES NO If YES, how much? _____

Do you smoke? YES NO If YES, how much? _____ How many years? _____