Medical Health Questionnaire

Please Complete As Much As Possible

Name_____ Medical Record_____

Date _____

Reason For Visit: _____

Who Referred You To Our Practice: _____

Primary Care Physician: _____

EYE SYMPTOMS (do you currently have any of the following symtoms?)

	Yes	No		Yes	No
Blurred Vision	☐	☐	Eye Pain or Soreness	☐	☐
Distorted Vision	☐	☐	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 Illness' _____

List Any Surgeries _____

MEDICATIONS Please List ALL Prescriptions and OTC Meds: _____

_____

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/gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, 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/frequent urination, impotence, yellow jandice, 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)			
Endocrine (diabetes, hyperthyroid, etc)			
Psychiatric (anxiety, depression, insomnia ect)			
Blood/Lymph (bleeding, cholesterolemia, anemia problems, blood transfusions, etc)			
Allergic, Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc)			

FAMILY HISTORY Has any members of your family had these diseases? *YES* *NO* *UNKNOWN*

(CIRCLE ALL THAT APPLY) Blindness, Glaucoma, Diabetes, Hypertension, Macular Degeneration

Other genetic eye disease:

SOCIAL HISTORY Does your vision limit any activities (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?_____