Medical History Questionnaire

Patient Name: _____ Birth Date: _____ Today's Date: _____

Reason for Today's Appointment: _____

Medical/Social History

List any medical conditions you have: _____

List any medications you take (including eye drops, vitamins, over the counter): _____

_____

Do you have any allergies? ☐ No ☐ Yes If yes, explain: _____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long? _____

Are you pregnant or nursing? ☐ No ☐ Yes Do you wear glasses? ☐ No ☐ Yes If yes, how old are they? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what brand? _____ Solution used? _____

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____

Review of Systems

Do you currently or have you ever had any problems in the following areas?

SYSTEM	NO	YES	explain
EYES/VISION			
Blurred Vision	□	□	
Double Vision	□	□	
Mucous Discharge	□	□	
Redness	□	□	
Dryness	□	□	
Sandy/Gritty Feeling	□	□	
Itching	□	□	
Burning	□	□	
Watering/Excess Tearing	□	□	
Glare/Light Sensitivity	□	□	
Eye Pain/Soreness/Tired Eyes	□	□	
Flashes/Floaters in Vision	□	□	
Styes or Chalazion	□	□	
Previous Eye Surgeries	□	□	
EAR, NOSE, MOUTH, THROAT			
Hearing Loss	□	□	
Sinus Congestion	□	□	
Chronic Cough	□	□	
Dry Throat/Mouth	□	□	
RESPIRATORY			
Asthma	□	□	
Emphysema	□	□	

SYSTEM	NO	YES	explain
CARDIOVASCULAR			
Diabetes	□	□	
High Blood Pressure	□	□	
Stroke	□	□	
ENDOCRINE (thyroid/other glands)	□	□	
GASTROINTESTINAL			
Constipation	□	□	
Irritable Bowel Syndrome	□	□	
GENITOURINARY (genitals/kidney)	□	□	
HEMATOLOGIC / LYMPHATIC			
Anemia	□	□	
Bleeding Problems	□	□	
INTEGUMENTARY (skin)	□	□	
MUSCULOSKELETAL			
Rheumatoid Arthritis	□	□	
Muscle/Joint Pain	□	□	
NEUROLOGIC			
Headaches	□	□	
Migraines	□	□	
Seizures	□	□	
PSYCHIATRIC			
Anxiety	□	□	
Depression	□	□	