CENTER FOR EXCELLENCE IN EYE CARE

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List any **medications** you currently take (prescription and over-the-counter)

_____

_____

List any surgeries you have had:

_____

Do you have allergies to any **medications**? ☐ YES ☐ NO
If **YES**, list the medications:

_____

Reason for today's visit: (Please check one of the following)

☐ Routine eye exam & refraction (the exam to determine the prescription of glasses)
☐ Medical Problem: ☐ Diabetic ☐ Glaucoma ☐ Retinal Disorder ☐ Cataracts ☐ Eye Infection

☐ Other _____

Do you ***currently*** have any problems in the following areas? If "YES", please provide and explanation

	YES	**NO**	**Explanation of Problem**
EYES Glaucoma, cataract, retinal disease, etc.)			
Loss of Vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision (halos)			
Loss of side vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing/ Watering			
Glare/Light Sensitivity			
Eye Pain or Soreness			
Infection of Eye or Lid (blepharitis, stye)			
Tired Eyes			
Crossed Eyes, Lazy Eye			
Drooping Eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			

	YES	NO	Explanation of Problem
EARS, NOSE THROAT (sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (heart, vessels, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (arthritis, etc)			
SKIN (acne, warts, skin cancer, etc.)			
NEUROLOGICAL (multiple sclerosis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY **M= Mother** **F= Father** **S=Sibling** **GP= Grandparent**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current Occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (single, married, divorced, widowed): _____

	YES	NO	
Do you Drive?			
Do you have visual difficulty when driving?			
Do you have problems with night vision?			
Have you ever tried to wear contact lenses?			
Do you currently wear contact lenses?			If YES, how long?
Do you currently wear glasses?			If Yes, how long have you had the current prescription?
Do you drink alcohol?			If Yes: occasional 1 per day 2-3 per day 4+/day
Do you smoke?			If Yes: occasional ½ pack/day 1 pack/day 1+ pack/day
Have you ever had a blood transfusion?			

Physician's Signature: _____ Date: _____

Patient's Signature: _____ Date _____