



MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date: _____

Date of your last physical exam: _____ Last eye exam: _____

Please check any medical history that is related to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Accutane User | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Plaquenil User |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Prostate Medication User |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV | <input type="checkbox"/> Sjogren's Syndrome |
| <input type="checkbox"/> Collagen Tissue Disease | <input type="checkbox"/> Lesions | <input type="checkbox"/> Sore throat / Recent fever |
| <input type="checkbox"/> Coumadin User | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Dizziness | | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Other _____ | | |

List all allergies including medications: _____

List all medications you are currently using including drops: _____

List all surgeries: _____

List any eye disease, infection, injury, and if you wear contacts: _____

Do you smoke? _____ If so, how many packs per day? _____

Do you drink? _____ If so, how many drinks per day, week, month? _____

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CURRENT VISION ISSUES:

Please check any of the symptoms you have experienced:

- | | |
|--|--|
| <input type="checkbox"/> Change in vision
(if yes) <input type="checkbox"/> Distant <input type="checkbox"/> Near | <input type="checkbox"/> Distorted vision |
| <input type="checkbox"/> Pain in the eye | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Chalazion / styne | <input type="checkbox"/> Crossed eye / lazy eye |
| <input type="checkbox"/> Blurry, Cloudy vision | <input type="checkbox"/> Redness or discharge |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Dry, itchy eye |
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Excessive tearing |
| <input type="checkbox"/> Pain in the eye | <input type="checkbox"/> Spider web / floaters / flashes |
| <input type="checkbox"/> Rainbows / Halos | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Double vision |
| | <input type="checkbox"/> Ocular Herpes |

FAMILY HISTORY

Please check if illness applies:

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Sjogren's syndrome | <input type="checkbox"/> High blood pressure |

Occupation: _____

Is this visit related to a work injury? _____

Are you pregnant, or have been pregnant within the last 3 months? _____

Are you currently nursing? _____

Please note the reason for this visit:

 _____
Patient Signature

Date