

Medical History Questionnaire

❖ *Please complete front and back of both*

Name _____ Birth Date _____

Name of **referring** physician _____ Physician phone _____

Name of **family** physician _____ Physician phone _____

HISTORY OF PRESENT ILLNESS

Please explain in your own words the problem with your eye(s). Please include the location, duration, and severity of this problem. Also mention what makes the problem worse or better and any associated signs or symptoms.

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If “yes”, provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms			
Fever	_____	_____	_____
Weight Loss	_____	_____	_____
Other	_____	_____	_____
Eyes			
Loss of vision	_____	_____	_____
Blurred vision	_____	_____	_____
Distorted vision (halos)	_____	_____	_____
Loss of side of vision	_____	_____	_____
Double vision	_____	_____	_____
Dryness	_____	_____	_____
Mucous discharge	_____	_____	_____
Redness	_____	_____	_____
Sandy or gritty feeling	_____	_____	_____
Itching/Burning	_____	_____	_____
YES NO Explanation of Problem			
Foreign body sensation	_____	_____	_____
Excess tearing/watering	_____	_____	_____
Occasional tearing	_____	_____	_____
Glare/Light sensitivity	_____	_____	_____
Eye pain or soreness	_____	_____	_____

Chronic infection of eye	_____	_____	_____
Sties, Chalazion	_____	_____	_____
Fluctuating vision	_____	_____	_____
Tired eyes	_____	_____	_____
Ears, nose, mouth, throat			
Sinus congestion	_____	_____	_____
Runny nose	_____	_____	_____
Post-nasal drip	_____	_____	_____
Chronic cough	_____	_____	_____
Dry throat/mouth	_____	_____	_____
Cardiovascular (heart/blood vessels)	_____	_____	_____
Respiratory (lungs/breathing)	_____	_____	_____
Chronic bronchitis	_____	_____	_____
Gastrointestinal (stomach/intestines)	_____	_____	_____
Genitourinary (genitals/kidney/bladder)	_____	_____	_____
Musculoskeletal (Muscle/Joint)	_____	_____	_____
Integumentary (skin and/or breast)	_____	_____	_____
Neurological	_____	_____	_____
Psychiatric	_____	_____	_____
Endocrine (Insulin Dependent Diabetes	_____	_____	_____
Non-Insulin Dependent Diabetes	_____	_____	_____
Hematologic/Lymphatic/Blood	_____	_____	_____
	YES	NO	Explanation of Problem
Lymph nodes	_____	_____	_____
Swelling	_____	_____	_____
Allergic/Immunologic	_____	_____	_____
Head allergy symptoms	_____	_____	_____
Seasonal allergies	_____	_____	_____
Hay fever symptoms	_____	_____	_____

PAST HISTORY

List any medications you currently take: _____

List all major illnesses and injuries: _____

List any surgeries you have had: _____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes? If so, explain:

Do you have allergies to any medications? YES NO
If YES, list medications: _____

FAMILY HISTORY

Disease	YES	NO	Relationship to patient
Blindness	_____	_____	_____
Cataract	_____	_____	_____
Glaucoma	_____	_____	_____
Macular degeneration	_____	_____	_____
Retinal detachment	_____	_____	_____
Arthritis	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart attacks	_____	_____	_____
High blood pressure	_____	_____	_____
Kidney disease	_____	_____	_____
Lupus	_____	_____	_____
Sjogrens Syndrome	_____	_____	_____
Stroke	_____	_____	_____
Thyroid disease	_____	_____	_____
Tuberculosis	_____	_____	_____

Retinal dystrophy _____
Keratoconus _____
Other _____

SOCIAL HISTORY

Current Occupation _____

Do you drive? _____ YES _____ NO
Do you have visual difficulty when driving? _____ YES _____ NO
Do you have problems with night vision? _____ YES _____ NO
Have you ever tried to wear contact lenses? _____ YES _____ NO
 Daily wear? _____ YES _____ NO
 Extended wear? _____ YES _____ NO
 Disposables? _____ YES _____ NO
 Rigid lenses? _____ YES _____ NO
 Soft lenses? _____ YES _____ NO

Describe lens care regimen _____

Do you currently wear glasses? _____ YES _____ NO
If YES, how long have you had the current prescription? _____

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

Do you smoke? _____ YES _____ NO
If YES, how many packs a day? _____

Have you ever had a blood transfusion? _____ YES _____ NO
Have you ever been in intimate contact with a person who had a sexually transmitted disease? _____ YES _____ NO

Patient's signature _____ **Date** _____

Physician's signature _____ **Date** _____

I have reviewed the patient's history detailed above and have added comments where indicated. Otherwise, there are no changes.

