Patient Name:____ Date:___________________________

Medical History and Questionnaire

We are asking you to fill out this complete medical history and questionnaire because many diseases and conditions can affect your eyes. All of the information on this form is kept strictly confidential. If you are unable to complete form on your own, one of our staff members will assist you.

For subsequent visits
Patient Reviewed (initial + date)
______________ ☐
______________ ☐
______________ ☐

Review of systems:

Do you have problems in the following areas?

Eyes

	Y	N
Loss of vision	☐ Y	☐ N
Blurred vision	☐ Y	☐ N
Distorted vision	☐ Y	☐ N
Double vision	☐ Y	☐ N
Dryness	☐ Y	☐ N
Mucous discharge	☐ Y	☐ N
Redness	☐ Y	☐ N
Itching	☐ Y	☐ N
Burning	☐ Y	☐ N
Foreign body sensation	☐ Y	☐ N
Excess watering	☐ Y	☐ N
Light sensitivity or glare	☐ Y	☐ N
Eye pain or soreness	☐ Y	☐ N
Sties or chalazion	☐ Y	☐ N
Flashes / floaters in vision	☐ Y	☐ N
Eye injury	☐ Y	☐ N
Eye surgery	☐ Y	☐ N

Respiratory

	Y	N
Asthma	☐ Y	☐ N
Chronic bronchitis	☐ Y	☐ N
Emphysema	☐ Y	☐ N

Vascular / Cardiovascular

	Y	N
Diabetes	☐ Y	☐ N
Heart pain	☐ Y	☐ N
High blood pressure	☐ Y	☐ N
Vascular disease	☐ Y	☐ N

Endocrine

	Y	N
Thyroid / other glands	☐ Y	☐ N

Genitourinary

	Y	N
Genital / Kidney / Bladder	☐ Y	☐ N

Gastrointestinal

	Y	N
Diarrhea	☐ Y	☐ N
Constipation	☐ Y	☐ N

Bones / Joints / Muscles

	Y	N
Rheumatoid arthritis	☐ Y	☐ N
Muscle pain	☐ Y	☐ N
Joint pain	☐ Y	☐ N

	Y	N
Allergic / Immunologic	☐ Y	☐ N
Psychiatric	☐ Y	☐ N

Constitutional

	Y	N
Fever	☐ Y	☐ N
Weight Loss / Gain	☐ Y	☐ N

	Y	N
Integumentary (Skin)	☐ Y	☐ N
Cancer	☐ Y	☐ N

Neurological

	Y	N
Headaches	☐ Y	☐ N
Migraines	☐ Y	☐ N
Seizures	☐ Y	☐ N

Lymphatic / Hematologic

	Y	N
Anemia	☐ Y	☐ N
Bleeding problems	☐ Y	☐ N

Ear, Nose, Mouth, Throat

	Y	N
Allergies / Hay Fever	☐ Y	☐ N
Sinus congestion	☐ Y	☐ N
Runny nose	☐ Y	☐ N
Post-Nasal Drip	☐ Y	☐ N
Chronic cough	☐ Y	☐ N
Dry throat / mouth	☐ Y	☐ N

Family History:

Please note any family history (parents / grandparents / siblings / children) for the following conditions:

	Y	N	Relation to you:
Blindness	☐ Y	☐ N	________________
Glaucoma	☐ Y	☐ N	________________
Cataracts	☐ Y	☐ N	________________
Macular degeneration	☐ Y	☐ N	________________
Retinal detachment	☐ Y	☐ N	________________
Amblyopia (lazy eye)	☐ Y	☐ N	________________
Eye turn	☐ Y	☐ N	________________
Diabetes	☐ Y	☐ N	________________
High blood pressure	☐ Y	☐ N	________________
Thyroid disease	☐ Y	☐ N	________________

Please answer the following:

Are you currently taking medications?... ☐ Y ☐ N (Please include all prescription, over-the-counter, and herbal medicines.)

If yes, please list: ____

____

____

Are you pregnant and / or nursing?…… ☐ Y ☐ N

Are you allergic to any medications?..... ☐ Y ☐ N If yes, please list: ________________________________

Do you drive?…………………………… ☐ Y ☐ N If yes, do you have any visual difficulty when driving?….. ☐ Y ☐ N

Do you consume alcohol?……………… ☐ Y ☐ N If yes, type / amount / how often:________________________

Do you use illegal drugs?...................... ☐ Y ☐ N If yes, type / amount / how often:________________________

Do you use tobacco products?………… ☐ Y ☐ N If yes, type / amount / how often:________________________

Are you a carrier of or infected with:…. ☐ None ☐ HIV ☐ Gonorrhea ☐ Syphilis ☐ Hepatitis

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Doctor's signature:______________________________ Date:__________ __________ __________