



## **MEDICAL HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

\_\_\_\_\_

Do you have any allergies to medications?    \_\_\_ No    \_\_\_ Yes

If yes, explain: \_\_\_\_\_

List all major injuries or surgeries to your eyes: \_\_\_\_\_

Do you wear glasses?    \_\_\_ No    \_\_\_ Yes

Do you wear contact lenses?    \_\_\_ No    \_\_\_ Yes    Brand of contact lenses \_\_\_\_\_

Type of contact lenses:    \_\_\_ Rigid    \_\_\_ Soft    \_\_\_ Extended Wear    \_\_\_ Other

Are you pregnant or nursing?    \_\_\_ No    \_\_\_ Yes    Due Date: \_\_\_\_\_

Do you drink alcohol:    \_\_\_ No    \_\_\_ Yes    If yes, type/amount/how long \_\_\_\_\_

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

Do you use illegal drugs?    \_\_\_ No    \_\_\_ Yes    If yes, type/amount/how long \_\_\_\_\_

### **FAMILY HISTORY**

Please note any family history (parents, grandparents, siblings) for the following:

	No	Yes	Relationship to You
Blindness	_____	_____	_____
Retinal Detachment/Disease	_____	_____	_____
Cataract	_____	_____	_____
Crossed Eyes /"Lazy Eye"	_____	_____	_____
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Arthritis	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____

### **REVIEW OF SYSTEMS**

Do you currently have or have you ever been treated for:

<b><i>EYES</i></b>	No	Yes	<b><i>VASCULAR/CARDIO</i></b>	No	Yes
Glaucoma	___	___	High Blood Pressure	___	___
Macular degeneration	___	___	Heart Disease	___	___
Cataracts	___	___	High Cholesterol	___	___
Retinal Disease/detachment	___	___			
Lazy Eye(s)	___	___	<b><i>NEUROLOGICAL</i></b>		
Double Vision	___	___	Headaches	___	___
Loss of Side Vision	___	___	Migraines	___	___
Flashes/Floaters	___	___	Seizures	___	___
Blurred Vision	___	___			
Burning	___	___	<b><i>ENDOCRINE</i></b>		
Dryness	___	___	Thyroid Disease/Dysfunction	___	___
Redness	___	___	Diabetes Type 1		___
Foreign Body Sensation	___	___	Diabetes Type 2		___
Sandy or Gritty Feeling	___	___			
Sty or Chalazion	___	___			
Eye Pain or Soreness	___	___	<b><i>LYMPHATIC/HEMATOLOGIC</i></b>		
Mucous Discharge	___	___	Bleeding Problems	___	___
Glare/Light Sensitivity	___	___	Anemia	___	___
Excess Tearing/Watering	___	___			
Itching	___	___			
			<b><i>ALLERGIC/IMMUNOLOGIC</i></b>		
<b><i>BONES/JOINTS/MUSCLES</i></b>			Lupus	___	___
Rheumatoid Arthritis	___	___	HIV	___	___
Osteoarthritis	___	___			
Osteoporosis	___	___	<b><i>OTHER- PLEASE EXPLAIN:</i></b>		
			_____		
<b><i>RESPIRATORY</i></b>			_____		
Asthma	___	___	_____		
Chronic Bronchitis	___	___			
Emphysema	___	___			