## MEDICAL HISTORY QUESTIONNAIRE

Patient name _____

Street address _____ Today's date _____

City, state, zip _____ Date of birth _____ Age ____

Home phone _____ Place of birth _____

Work phone _____ Occupation _____

**Referred by** _____ Phone number _____

Address _____

**Medical doctor** _____ Phone number _____

Address _____

**Eye doctor** _____ Phone number _____

Address _____

### VISION HISTORY

**Do you wear:**

☐YES ☐NO glasses

☐YES ☐NO contact lenses

☐YES ☐NO an artificial eye

**Have you ever had:**

☐YES ☐NO cataract

☐YES ☐NO glaucoma

☐YES ☐NO diabetes

☐YES ☐NO lazy eye

☐YES ☐NO double vision

☐YES ☐NO decreased vision

☐YES ☐NO floaters

☐YES ☐NO halos

☐YES ☐NO flashing lights

☐YES ☐NO abnormal light sensitivity

☐YES ☐NO blind spots

☐YES ☐NO jagged lines in your vision

☐YES ☐NO poor side vision

☐YES ☐NO poor night vision

☐YES ☐NO poor color perception

☐YES ☐NO poor depth perception

☐YES ☐NO retinal problems

☐YES ☐NO poor blood supply to eye

☐YES ☐NO serious eye infection

☐YES ☐NO abnormal pupil

☐YES ☐NO other, if so, what?

### MEDICAL HISTORY

**Do you have, or have you ever been treated for:**

☐YES ☐NO AIDS/HIV

☐YES ☐NO Alzheimer's

☐YES ☐NO anemia

☐YES ☐NO angina

☐YES ☐NO arthritis

☐YES ☐NO asthma

☐YES ☐NO atrial fibrillation

☐YES ☐NO Bell's palsy

☐YES ☐NO cancer

☐YES ☐NO cardiovascular disease

☐YES ☐NO COPD

☐YES ☐NO congestive heart failure

☐YES ☐NO coronary artery disease

☐YES ☐NO Crohn's disease

☐YES ☐NO diabetes insipidus

☐YES ☐NO diabetes type I

☐YES ☐NO diabetes type II

☐YES ☐NO enlarged prostate

☐YES ☐NO GERD

☐YES ☐NO gout

☐YES ☐NO Grave's disease

☐YES ☐NO Guillain Barre syndrome

☐YES ☐NO hepatitis

☐YES ☐NO hernia

☐YES ☐NO high blood pressure

☐YES ☐NO high cholesterol

☐YES ☐NO kidney disease

☐YES ☐NO kidney dialysis

☐YES ☐NO Lyme disease

☐YES ☐NO migraine

☐YES ☐NO myocardial infarction (heart attack)

☐YES ☐NO multiple sclerosis

☐YES ☐NO myasthenia gravis

☐YES ☐NO osteoporosis

☐YES ☐NO Parkinson'sdisease

☐YES ☐NO pulmonary embolism

☐YES ☐NO rheumatoid arthritis

☐YES ☐NO sarcoidosis

☐YES ☐NO seizures

☐YES ☐NO sickle-cell disease

☐YES ☐NO Sjogren's syndrome

☐YES ☐NO sleep apnea

☐YES ☐NO stomach ulcer

☐YES ☐NO stroke

☐YES ☐NO temporal arteritis

☐YES ☐NO transient ischemic attack (TIA)

☐YES ☐NO thyroid disease

☐YES ☐NO other, if so what?

## MEDICAL HISTORY QUESTIONNAIRE – page 2

### SURGICAL HISTORY

Please list any surgeries you have had, with the dates:

### CURRENT MEDICATION

List all of your current medications, with the strengths and dosages. Refer to the labels for accuracy. Be sure to include any prescription eye drops.

### ALLERGIES

☐YES ☐NO Penicillin

☐YES ☐NO Sulfa

☐YES ☐NO shellfish

Are you allergic to any other medicine? Please list the medicine and the reaction it caused:

### FAMILY HISTORY

Has anyone in your family ever had any of the following, and if so, who in the family? (mother, brother, grandparent, etc.):

☐macular degeneration

☐blindness

☐cataract

☐glaucoma

☐retinal detachment

☐amblyopia

☐diabetes

☐cancer

☐heart disease

☐hypertension

☐kidney disease

☐thyroid disease

☐stroke

☐uveitis

### SOCIAL HISTORY

☐YES ☐NO Do you smoke now?

How much?

☐YES ☐NO Have you ever smoked?

☐YES ☐NO Do you drink alcohol?

How often?

☐YES ☐NO Have you ever used drugs?

Are you:

☐YES ☐NO working

if so, type of work?

☐YES ☐NO unemployed

☐YES ☐NO disabled

☐YES ☐NO retired

## REVIEW OF SYSTEMS

**Do you have any of the following?**

☐YES ☐NO chest pain

☐YES ☐NO shortness of breath

☐YES ☐NO swelling in feet/ankles

☐YES ☐NO irregular heartbeat

☐YES ☐NO fever

☐YES ☐NO weight loss

☐YES ☐NO fatigue

☐YES ☐NO night sweats

☐YES ☐NO excessive thirst

☐YES ☐NO excessive urination

☐YES ☐NO heat intolerance

☐YES ☐NO cold intolerance

☐YES ☐NO abdominal pain

☐YES ☐NO nausea

☐YES ☐NO trouble swallowing

☐YES ☐NO painful urination

☐YES ☐NO blood in urine

☐YES ☐NO dialysis

☐YES ☐NO easy bruising

☐YES ☐NO prolonged bleeding

☐YES ☐NO hearing loss

☐YES ☐NO scalp tenderness

☐YES ☐NO jaw pain when chewing

☐YES ☐NO rashes

☐YES ☐NO skin sores

☐YES ☐NO skin cancer

☐YES ☐NO severe itching

☐YES ☐NO muscle aches

☐YES ☐NO joint pain

☐YES ☐NO weakness

☐YES ☐NO seizures

☐YES ☐NO dizziness

☐YES ☐NO cough

☐YES ☐NO coughing up blood

SUBMIT PRINT CLEAR