the eye clinic p.c.

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Date of birth:_____ Current occupation: _____

Primary care doctor:_____ Date of last visit and reason:_____

Date of last eye exam:_____ Location/doctor for last eye exam:_____

Do you drive? ☐ YES ☐ NO

If yes, do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you tried to wear contact lenses? ☐ YES ☐ NO

If yes, how long have you worn contact lenses? _____

Do you currently wear prescription glasses? ☐ YES ☐ NO

If yes, how long have you had the current prescription? _____

Do you **currently** have any problems in the following areas? If YES, please provide information.

EYES	YES	NO	Explanation of Problem
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching/burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
OTHER			

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy): _____

_____

Please turn page over ⇨

Do you **currently** have any problems in the following areas? If YES, please provide information.

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (Fever, weight loss, other)			
CARDIOVASCULAR (Heart, vessels, etc.)			
EAR, NOSE, MOUTH, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITOURINARY (Genital, kidney, bladder)			
MUSCULOSKELETAL (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypo/hyperthyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	**RELATIONSHIP TO PATIENT**	**DISEASE**	YES	NO	**RELATIONSHIP TO PATIENT**
Glaucoma				Diabetes			
Cataracts				Cancer			
Macular Degeneration				Heart Disease			
Eye Injury				Hypertension			
Retinal Disease				High Cholesterol			
Other Disease				Kidney Disease			
Blindness				Stroke			
Strabismus				Other (describe)			
Amblyopia				Other (describe)			

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1/day 2-3/day 4+/day

What is your smoking history/current use status? ☐ Current smoker: occasional ½ pack/day 1 pack/day 1+ pack/day

☐ Former smoker: how long ago did you quit smoking? _____

☐ Never smoked

Do you use recreational drugs? ☐ YES ☐ NO

List any **medications** you currently take (prescription and over-the-counter, including supplements):

_____

_____

Do you have **allergies** to any medications? ☐ NO ☐ YES (please list) _____