Print Form

Medical History Questionnaire

Name: _____ Today's Date: ____/____/____ (Month / Day / Year)

Last Eye Exam ____/____ (Month / Year) Last Medical Exam ____/____ (Month / Year) Current Medical Dr. _____

List all medications (including birth control, OTC, etc.) _____

List allergies (including medication allergies) _____

- Do you wear glasses Yes No
  - If Yes, how old is your current pair?_____
- Do you wear contact lenses Yes No
  - If Yes, how old is your current pair?_____
- Have you had refractive surgery Yes No

Health Habits: (check the substance you use)

	Yes	No
Alcohol - Quantity / How often _____	☐	☐
Recreational Drugs - Quantity / How often _____	☐	☐
Tobacco - Quantity / How often _____	☐	☐

Social History: (tell us about your hobbies or interests)_____

Review of Systems

Eyes	NO	Self	Family (who)
Blindness	☐	☐	☐
Cataract	☐	☐	☐
Crossed Eyes	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment	☐	☐	☐
Distance / Near Blur	☐	☐	☐
Distorted vision	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of the Eye	☐	☐	☐
Sties	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐

Constitutional	NO	Self	Family (who)
Fever, weight loss / gain	☐	☐	☐
Integumentary			
Skin Problems	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Ear, Nose, Mouth, Throat			
Allergies or Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Psychiatric	☐	☐	☐
Allergic / Immunologic	☐	☐	☐

Vascular / Cardiovascular	NO	Self	Family (who)
Diabetes	☐	☐	☐
Heart Pain / Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Lupus	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Problems w/ Genitalia/Kidney/Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic / Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Endocrine			
Thyroid / Other Glands	☐	☐	☐
Other (please specify)			

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