

Medical History Questionnaire

Name _____ **Date** _____

Date of birth _____ Date of last eye exam _____

Referring Dr. _____ Primary Care Physician _____

What is the chief complaint regarding your eyes? _____

List any medications you currently take (prescription and over-the-counter): _____

Do you have allergies to any medications? YES NO If YES, list the medications: _____

Have you ever taken Mellaril (Thioridazine), Chloroquine, Plaquenil, or Tamoxifen? YES NO

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

List any surgeries you have had (cataract, tonsils, appendix, etc.) _____

Do you currently have any of the problems below? If YES, please give details:

| EYES | RIGHT | LEFT | NO | EXPLANATION OF PROBLEM |
|---------------------|-------|------|----|------------------------|
| Loss of vision | | | | |
| Distorted vision | | | | |
| Loss of side vision | | | | |
| Double vision | | | | |
| Itching | | | | |
| Tearing/watering | | | | |
| Pain | | | | |
| Crossed or lazy eye | | | | |
| Drooping eyelid | | | | |
| Cataract | | | | |
| Glaucoma | | | | |
| Flashes | | | | |
| Floaters | | | | |
| Retinal Tear | | | | |
| Retinal detachment | | | | |
| Retinal laser | | | | |
| Eye trauma | | | | |

| | YES | NO | EXPLANATION OF PROBLEM |
|---|-----|----|------------------------|
| GENERAL/CONSTITUTIONAL (Fever) | | | |
| (Weight loss) | | | |
| EARS, NOSE, THROAT (Sinus infections) | | | |
| (ear infection, chronic cough, dry mouth) | | | |
| CARDIOVASCULAR (Heart Attack) | | | |
| (High blood pressure) | | | |
| RESPIRATORY (Asthma) | | | |
| (Emphysema) | | | |
| GASTROINTESTINAL (Stomach ulcers) | | | |
| (Hepatitis) | | | |
| GENITAL, KIDNEY (Kidney stones) | | | |
| (Dialysis) | | | |
| MUSCLES, BONES, JOINTS (Arthritis) | | | |
| (Polymyalgia rheumatica) | | | |
| SKIN (Acne, warts, skin cancer) | | | |
| NEUROLOGICAL (Stroke) | | | |
| (Multiple sclerosis) | | | |
| ENDOCRINE (thyroid) | | | |
| Diabetes [how long?] | | | |
| BLOOD/LYMPH (Cholesterol, anemia) | | | |
| (Taking blood thinners) | | | |
| INFECTIOUS DISEASE (Syphilis, TB, HIV) | | | |
| ALLERGIC/IMMUNOLOGIC (Lupus, Sjogrens) | | | |

FAMILY HISTORY

M=Mother, F=Father, S=Sibling, GP=Grandparents

| DISEASE | YES | NO | RELATIONSHIP TO PATIENT |
|----------------------|-----|----|-------------------------|
| Retinal Detachment | | | |
| Macular Degeneration | | | |
| Glaucoma | | | |
| Cancer | | | |
| Diabetes | | | |

SOCIAL HISTORY

Current or prior occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living Arrangements: _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

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

Do you smoke? YES NO If YES: occasional 1 per day 2-3/day 4+/day

Have you ever had a blood transfusion? YES NO

History reviewed. No changes. Additions as noted above.

Physician's Signature: _____ Date: _____