PATIENT MEDICAL HISTORY QUESTIONAIRE

(This form is designed to aid the doctor in identifying problems and risks)

Last Name _____ First Name _____ MI _____ Age _____ Today's Date _____

What is the main reason for today's visit? _____

Do you have any allergies to medications? (Y/N) If yes, list: _____

Current medications (RX or over the counter, including eye drops, vitamins, aspirin, or oral contraceptives):

_____

Current and Past Eye and Vision History: Please answer each question. Circle **None** or **No** if does not apply.

Describe past eye injuries, surgeries, or infections (⦶ None) _____
Do you wear **eyeglasses**? (Y/N) For what activities? (⦶ Full-Time) _____
Do you wear **contacts**? (Y/N) Do you sleep in them? (Y/N) What type are they? _____ Solution _____
Are you interested in trying contact lenses? (Y/N) Are you interested in colored contact lenses? (Y/N)
If you wear contact lenses, are you satisfied with the vision and comfort? (Y/N)

Do you have?

Glaucoma	(Y/N)	Cataracts	(Y/N)	Macular Degeneration	(Y/N)	Blurred Vision	(Y/N)	Eye Irritation	(Y/N)
Dry Eyes	(Y/N)	Tearing	(Y/N)	Light Sensitivity	(Y/N)	Eye Inflammation	(Y/N)	Sandy/Gritty Feeling	(Y/N)
Flashes	(Y/N)	Floaters	(Y/N)	Fluctuating Vision	(Y/N)	Loss of Vision	(Y/N)	Double Vision	(Y/N)
Redness	(Y/N)	Burning	(Y/N)	Mucus Discharge	(Y/N)	Tired Eyes	(Y/N)	Crossed Eyes	(Y/N)
Eye Pain	(Y/N)	Itching	(Y/N)	Lazy Eye	(Y/N)				

How long since your last eye exam? _____ By Whom? _____ Were your eyes dilated? (Y/N/don't know)
Name of Family Physician _____ **Date of Last Physical Exam** _____

Medical History: Please mark each box that applies to a condition for which you have been diagnosed. If none, mark **None**.

Allergic/Immunologic ⦶ NONE
⦶ Environmental allergies
⦶ Lupus

Ear/Nose/Throat ⦶ NONE
⦶ Upper resp tract infection
⦶ Hearing loss

Neurological ⦶ NONE
⦶ Multiple sclerosis ⦶ Migraines
⦶ Epilepsy/seizures
⦶ Headaches

Hematological ⦶ NONE
⦶ Anemia
⦶ Leukemia
⦶ Cancer

Cardiovascular ⦶ NONE
⦶ Heart disease
⦶ Hypertension
⦶ Stroke
⦶ Vascular disease

Endocrine ⦶ NONE
⦶ Diabetes
⦶ Thyroid dysfunction
⦶ Hormone replacement

Psychiatric ⦶ NONE
⦶ Depression
⦶ Panic disorder

Musculoskeletal ⦶ NONE
⦶ Fibromyalgia ⦶ Ankylosing spondylitis
⦶ Osteoarthritis ⦶ Muscular dystrophy
⦶ Rheumatoid arthritis

Respiratory ⦶ NONE
⦶ Asthma
⦶ Bronchitis
⦶ Emphysema

Gastrointestinal ⦶ NONE
⦶ Diarrhea
⦶ Constipation

Constitutional ⦶ NONE
⦶ Weight loss/gain (unexplained)
⦶ Fever

Other Conditions
⦶ _____
⦶ _____
⦶ _____

Skin ⦶ NONE
⦶ Eczema/rosacea/psoriasis
⦶ Skin cancers

Genitourinary ⦶ NONE
⦶ STD-herpetic, chlamydia
⦶ Kidney/bladder

Family History: ⦶ I am adopted or do not know my family history **(Please mark for each condition that applies)**.

Do you know of any blood-related family members with any of the following conditions? (Please list relation if applies)

⦶ Glaucoma _____
⦶ Cataract _____
⦶ Macular degeneration _____
⦶ Retinal detachment _____
⦶ Crossed eye/ lazy eye _____
⦶ Blindness _____
⦶ Diabetes _____
⦶ Heart disease _____
⦶ Hypertension _____
⦶ Cancer _____

Social/Occupational/Hobbies History:

Do you… (check box if yes)

⦶ Participate in sports? Please list _____
⦶ Use computers more than an hour a day?
⦶ Experience eyestrain working on the computer?
⦶ Have interest in a "test drive" of the latest contact lens design?
⦶ Have interest in non-surgical approach to vision correction?
⦶ Have children at home?
⦶ Spend time outdoors? How much? _____ hrs/week
⦶ Have prescription sunglasses?
⦶ Prefer not to wear glasses at times?
⦶ Want information on Laser Vision Correction Surgery?
⦶ Have more than one pair of current prescription glasses?
⦶ Have family members in need of eyecare?

- How long can you read before your eyes bother you or you get a headache? ⦶ NEVER _____
- What are your hobbies or pastimes (other than sports)? _____
- Do you use tobacco products? (Y/N) If yes, type/amount/how long _____
- Do you drink alcohol? (Y/N) If yes, type/amount/how long _____