# Medical History Questionnaire

Patient Name: ______________________________________________________

Date:____________________________

## MEDICAL HISTORY

Physician:_____________________________________________Town:_________________________

Name of Pharmacy:__________________________ Town: _______________________

Date of last eye exam if not done here:_______________________________________________

Do you have any allergies to medications? ______________________________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

_________________________________________________________________________________

_________________________________________________________________________________

Please list all medical conditions you are currently being treated for by a physician______________________

_________________________________________________________________________________

List all major injuries, surgeries, and /or hospitalizations you have had______________________________

_________________________________________________________________________________

Are you pregnant and/or nursing? No Yes
Do you wear glasses? No Yes if yes, how old is your present pair?______________

Do you wear contact lenses? No Yes if yes, how old are your present lenses?__________

Type of contact lenses: Rigid Soft Extended Wear Other___________________________

Are your contacts comfortable? No Yes

## SOCIAL HISTORY

Do you drive? No Yes
Do you use tobacco products? No Yes if yes, type/amount/how long_________________________

Do you drink alcohol? No Yes if yes, type/amount/how long___________________________
Do you use street drugs? No Yes

## REVIEW OF SYSTEMS:

Do you currently, or have you ever had any problems in the following areas:

**CONSTITUTIONAL**
Fever, Weight loss/gain no yes
**INTEGUMENTARY** (skin) no yes
**NEUROLOGICAL**
Headaches no yes

**EARS, NOSE, MOUTH, THROAT**
Allergies/hay fever no yes
Sinus congestion no yes
Runny nose no yes
Post-nasal drip no yes

| | | | | | |
|---|---|---|---|---|---|
| Migraines | no | yes | Chronic cough | no | yes |
| Seizures | no | yes | Dry throat/mouth | no | yes |

| **EYES** | | | **RESPIRATORY** | | |
|---|---|---|---|---|---|
| Loss of vision | no | yes | Asthma | no | yes |
| Blurred vision | no | yes | Chronic bronchitis | no | yes |
| Distorted vision/halos | no | yes | Emphysema | no | yes |
| Double vision | no | yes | **VASCULAR / CARDIOVASCULAR** | | |
| Dryness | no | yes | Diabetes | no | yes |
| Mucous discharge | no | yes | Heart Pain | no | yes |
| Redness | no | yes | High blood pressure | no | yes |
| Sandy or gritty feeling | no | yes | **GASTROINTESTINAL** | | |
| Burning | no | yes | Diarrhea | no | yes |
| Foreign body sensation | no | yes | Constipation | no | yes |
| Excess tearing/watering | no | yes | **GENITOURINARY** | | |
| Glare/light sensitivity | no | yes | Genitals/Kidney/Bladder | no | yes |
| Eye pain or soreness | no | yes | **BONES/JOINTS/MUSCLES** | | |
| Chronic infection of eye or lid | no | yes | Rheumatoid arthritis | no | yes |
| Sties or chalazion | no | yes | Muscle pain | no | yes |
| Flashes/floaters in vision | no | yes | Joint pain | no | yes |
| Tired eyes | no | yes | **LYMPHATIC/HEMATOLOGIC** | | |
| **ENDOCRINE** | | | Anemia | no | yes |
| Thyroid/other glands | no | yes | Bleeding problems | no | yes |
| Allergic/immunologic | no | yes | **PSYCHIATRIC** | no | yes |

If you answered YES to any of the above or have a condition not listed, please explain:

___________________________________________________________________________

___________________________________________________________________________

## FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following:

Blindness no yes _____________ Lupus no yes ____________________

Cataract no yes ______________ Thyroid Disease no yes_____________________

crossed eyes no yes ______________ Other______________________

Glaucoma no yes _______________

Macular Degeneration no yes _______________

Retinal Detachment/Disease no yes ________________

Arthritis no yes _______________

Cancer no yes ________________

Diabetes no yes ________________

Heart Disease no yes _________________

High Blood Pressure no yes _________________