MEDICAL HISTORY QUESTIONNAIRE

Name_____ Age_____ Birthdate_____

Was your last eye exam at our office?_____ If NO, Date of last eye exam_____ Dialated?_____

How old are your glasses?_____ Previous Eye Surgeries_____

Other Eye Problems (please check all that apply)

___ cataract ___ retinal disease ___ crossed eyes ___ macular degeneration

___ glaucoma ___ lazy eye ___ eye injuries (explain)_____

___ other_____

Please list any eye drops you are currently using_____

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH AND WELL BEING? (please check one)

___ Excellent ___ Good ___ Average ___ Fair ___ Poor

Comments:_____

NAME OF FAMILY DOCTOR:_____ Date of last visit_____

ALLERGIES TO MEDICATIONS: (please check the appropriate response)

___ NO KNOWN ALLERGIES TO MEDICATIONS

___ ALLERGIES TO THESE MEDICATIONS:_____

what type of reactions:_____

Are you pregnant Y N Due date:_____ Are you breast feeding? Y N

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

Allergic/Immunologic		
Seasonal allergy	Y	N
Rheumatoid arthritis	Y	N
Cancer	Y	N
Type_____		
Treatment_____		
Cardiovascular		
Heart disease	Y	N
High blood pressure	Y	N
Stroke	Y	N
Vascular disease	Y	N
Constitutuional		
Developmental disability	Y	N
Fever, weight loss/gain	Y	N
Ears, Nose, Mouth, Throat		
Sinus congestions	Y	N
Endocrine		
Diabetes	Y	N
Controlled	Y	N
Do you take Insulin?	Y	N
Do you take Pills?	Y	N
How many years?_____		
Gastrointestinal		
Stomach/liver problems	Y	N
Genitourinary		
Kidney/bladder problems	Y	N
STD	Y	N

Hermatologic/Lymphatic		
Anemia	Y	N
Integumentary		
Skin rash/cancer	Y	N
Rosacea	Y	N
Musculoskeletal		
Fibromyalgia	Y	N
Muscular dystrophy	Y	N
Neurological		
Headaches/dizziness	Y	N
Multiple sclerosis	Y	N
Epilepsy	Y	N
Psychiatric		
Depression	Y	N
Anxiety disorder	Y	N
Respiratory		
Asthma	Y	N
Chronic Obstructive Pulmonary Disease (COPD)	Y	N
Emphysema	Y	N
Social		
Tobacco use	Y	N
Alcohol	Y	N
Illegal substances	Y	N
Other _____		
_____		

FAMILY HISTORY (Do your parents or sibling have any of the following):

	YES	NO	RELATION
Glaucoma	____	____	_____
Retinal Disease	____	____	_____
Crossed Eyes	____	____	_____
Lazy Eye	____	____	_____

	YES	NO	RELATION
Cataract	____	____	_____
Diabetes	____	____	_____
High Blood Pressure	____	____	_____
Macular Degeneration	____	____	_____

FOR OFFICE USE ONLY: OPTOMETRIST SIGNATURE _____ **DATE**_____

PLEASE COMPLETE BOTH SIDES OF THE FORM