MEDICAL HISTORY QUESTIONNAIRE

Today's Date ____/____/2012

Name: ________________________________ Age: _____ Date of Birth: _____/ _____/ ________

Occupation: ____________________________

Medical Doctor: __________________________

Please list current medications:

__________________ __________________

__________________ __________________

__________________ __________________

__________________ __________________

Please list any health conditions or reasons for medications above:
(i.e. Hypertension, Diabetes, Thyroid, etc.)

__________________ __________________

__________________ __________________

__________________ __________________

List any surgeries or laser to your eyes you have had:

__________________ __________________

Are you allergic to any medications? If so, which ones?:

__________________ __________________

How old are your glasses? ______________

Do you wear contact lens? ______________

If yes, what kind? ____________________

EYE PROBLEMS:

Loss of Vision	YES	NO
Blurred Vision	YES	NO
Distorted Vision	YES	NO
Double Vision	YES	NO
Dryness	YES	NO
Redness	YES	NO
Itching	YES	NO
Burning	YES	NO
Excess Tearing	YES	NO
Glare/Light Sensitivity	YES	NO
Eye Pain or Soreness	YES	NO
Flashes/Floaters	YES	NO
Sties or Chalazion	YES	NO
Sandy Feeling	YES	NO
Chronic Infection	YES	NO
Droopy Eyelids	YES	NO
Wrinkles Around Eyes	YES	NO
Tired Eyes	YES	NO

MEDICAL HISTORY QUESTIONNAIRE ~ cont.

Name: ______________________________

DO YOU CURRENTLY HAVE OR HAVE HAD ANY PROBLEMS IN THE FOLLOWING AREAS?

CONSTITUTIONAL SYMPTOMS		
Fever	YES	NO
Weight Loss	YES	NO
EARS, NOSE, MOUTH, THROAT		
Sinus Congestion	YES	NO
Cough	YES	NO
Dry Mouth	YES	NO
CARDIOVASCULAR (Heart/Blood Vessels)		
High Blood Pressure	YES	NO
Heart Attack	YES	NO
Irregular Heart Beat	YES	NO
Congestive Heart Failure	YES	NO
RESPIRATORY (Lung/Breathing)		
Asthma	YES	NO
Bronchitis	YES	NO
Shortness of Breath	YES	NO
Tuberculosis	YES	NO
GASTROINTESTINAL (Stomach/Intestines)		
Colon/Bowel Trouble	YES	NO
MUSCULOSKELETAL		
Arthritis	YES	NO
Muscle Pain	YES	NO
CANCER / TUMORS	YES	NO
If yes, what type and location?		

INTEGUMENT (Skin Disease)		
Skin Cancer	YES	NO
Rosacea	YES	NO
NEUROLOGICAL		
Numbness	YES	NO
Weakness	YES	NO
Migraine	YES	NO
Stroke	YES	NO
ENDOCRINE		
Thyroid	YES	NO
Diabetes	YES	NO
ALLERGIC / IMMUNOLOGIC		
Seasonal Allergies	YES	NO
Hay Fever	YES	NO
BLOOD / LYMPHATICS		
Sickle-Cell Anemia	YES	NO
Leukemia	YES	NO
FAMILY HISTORY		
Glaucoma	YES	NO
Blindness	YES	NO
Cataracts	YES	NO
SOCIAL HISTORY		
Do you smoke?	YES	NO
Do you drive?	YES	NO
Do you drink alcohol?	YES	NO