MEDICAL HISTORY QUESTIONAIRE

NAME _____**DATE OF BIRTH**___/___/___ **TODAY'S DATE** ___/___/___

DATE OF LAST EYE EXAM_____

List any Medications you take_____

List all major illnesses and injuries_____

List any surgery you have had _____

Do you have any allergies to any medications? Yes_____ No_____ If YES, List medications_____

Review of Systems (Do you currently have any problems in the following areas? If YES, provide information.)

EYES	**YES**	**NO**	**EXPLANATION OF PROBLEM**
Loss of vision	_____	_____	_____
Blurred vision	_____	_____	_____
Double vision	_____	_____	_____
Mucous discharge	_____	_____	_____
Redness	_____	_____	_____
Sandy or gritty feeling	_____	_____	_____
Itching	_____	_____	_____
Burning	_____	_____	_____
Excess tearing	_____	_____	_____
Light sensitivity	_____	_____	_____
Eye pain	_____	_____	_____
Other	_____	_____	_____
EARS, NOSE, MOUTH, THROAT			
Sinus Congestion	_____	_____	_____
Runny Nose	_____	_____	_____
Chronic cough	_____	_____	_____
Other	_____	_____	_____
CARDIOVASCULAR			
Heart/blood vessels	_____	_____	_____
RESPIRATORY			
Lungs/breathing	_____	_____	_____
GASTROINTESTINAL			
Stomach/intestines	_____	_____	_____
GENITOURINARY			
Kidney/bladder	_____	_____	_____
MUSCULOSKELETAL			
Muscle pain	_____	_____	_____
Joint pain	_____	_____	_____
Other	_____	_____	_____
INTEGUMENTARY			
Skin	_____	_____	_____
NEUROLOGICAL	_____	_____	_____
ALLERGIC			
Seasonal allergies	_____	_____	_____
Hay fever	_____	_____	_____
Asthma	_____	_____	_____

FAMILY HISTORY	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness	_____	_____	_____
Cataract	_____	_____	_____
Crossed eyes/lazy eye	_____	_____	_____
Glaucoma	_____	_____	_____
Macular degeneration	_____	_____	_____
Retinal detachment	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Other	_____	_____	_____