

Medical History Questionnaire

Name: _____ Date: ____/____/____

Birth Date: ____/____/____ Last Medical Exam: ____/____/____ Last Eye Exam: ____/____/____ Eyes Dilated? Y/N

Name of Medical Doctor: _____ Dr's Phone: _____

How is your general health? _____

Do you have problems with any of these systems? (If YES, please explain and list medications)

SYSTEM	Yes	No	?	EXPLAIN/MEDICATIONS
EYES				
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR/HEART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES / JOINTS / MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC / HEMATOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE (thyroid/other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diabetes Y/N Type _____ Date of diagnosis _____

Allergies Y/N Allergic to what? _____ What happens? _____

Medication allergy Y/N What happens? _____ Headaches Y/N

Other health problems _____

Current medication(s) _____

Have you had any operations? Y/N Kind? _____ When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

Family History

High blood pressure Y/N Relation _____ Macular degeneration Y/N Relation _____

Diabetes Y/N Relation _____ Retinal detachment Y/N Relation _____

Glaucoma Y/N Relation _____ Cataracts Y/N Relation _____

Other eye conditions(s) Y/N What kind? _____ Relation _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____

Have you had an eye injury? Y/N Kind _____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N

Other eye problems? Y/N What kind? _____

Do you wear glasses? Y/N Contact lenses? Y/N Type _____