

Medical History Questionnaire

Name: _____ Date of Birth: _____ Age: _____

Height _____ Weight _____

Date of last eye exam: _____ Were you referred by a physician or optometrist? Y N If Yes, who? _____

List any **medications** you currently take (prescription and over-the-counter) or circle NONE:

Do you have any **allergies** to any medications? Y N If yes, please list: _____

List all major **illnesses** (glaucoma, diabetes, high blood pressure, heart attack) or **injuries** (concussion, etc.) or circle NONE:

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy) or circle NONE:

Self/Family History SE=self M=mother F=Father SI=Sibling GP=Grandparent

Do you or any members of your family have any eye disorders?

	Yes	No	Who?		Yes	No	Who?
Amblyopia (lazy eye)				Diabetic Retinopathy			
Glaucoma				Retinal Detachment			
Cataracts				Dry Eye			
Age Related Macular Degeneration				Cornea			
				Other			

If yes, please explain:

Do you or any members of your family have any general health problems?

	Yes	No	Who?		Yes	No	Who?
Ears, Nose, Throat (Sinus, ear infection, chronic cough, dry mouth, etc.)				Skin (Acne, warts, skin cancer, etc.)			
Cardiovascular (Heart, vessels, etc.)				Neurological (Multiple sclerosis, etc.)			
Respiratory (Asthma, emphysema, etc.)				Psychiatric (Anxiety, depression, insomnia, etc.)			
Gastrointestinal (Stomach ulcers, intestinal disease, etc.)				Endocrine (Diabetes, hypothyroid, etc.)			
Genital, Kidney, Bladder				Blood/Lymph (Cholesterolemia, anemia, etc.)			
Muscles, Bones, Joints (Arthritis, etc.)				Allergic/Immunologic (Hay fever, lupus, Sjogrens, etc.)			

If yes, please explain:

Social History

Current occupation: _____

Marital Status (please circle): Married Divorced Other

Do you currently wear glasses? Y N

If yes, how long have you had the current prescription? _____

Do you wear contacts? Soft Toric Gas Perm

How many hours per day? _____ How many years? _____

Living Arrangements: Independent Skilled Nursing Home

Do you Drive? Y N

Do you have visual difficulty when driving? Y N

Do you have problems with night vision? Y N

Do you drink alcohol? Y N How much? _____

Do you smoke? Y N How much? _____

Signature: _____ **Date:** _____