Medical Medical History Questionnaire

Reason for today's visit? _____

Date of most recent eye exam? ____yrs., Where? _____ Referring Dr (if being referred)? _____

Please list all **Eye Drops or Ocular medications** currently taking:

_____

Please list all **Other/Oral** both prescribed and over-the-counter **Medications** currently taking:

_____

Please list all **Allergies** including medication allergies and reaction it causes:

_____

PERSONAL OCULAR HISTORY: Have you had or been diagnosed with any of the following?

☐ glaucoma	☐ glaucoma suspect	☐ cataract	☐ macular degeneration
☐ surgery	☐ patching	☐ inflammation	☐ strabismus
☐ amblyopia	☐ retinal degeneration	☐ retinal hole	☐ retinal detachment
☐ keratoconus	☐ injury	☐ dry eye	☐ nystagmus

Please Specify any other **Eye Conditions** not listed above including history of eye injuries or surgeries:

_____

SOCIAL HISTORY: Drinking: □ No □ Yes **Tobacco Use:** □ No □ Yes **Smoking Status:** □ Never □ Current □ Former

Hobbies: _____

FAMILY OCULAR HISTORY: Please list all **Eye Conditions in the Family**:

_____

FAMILY MEDICAL HISTORY: Please list all **Medical Conditions in the Family**:

_____

REVIEW OF SYSTEMS: Do **you** currently, or have **you** ever had any problems in the following areas:

GENERAL/CONSTITUTIONAL:	☐ developmental disabilities ☐ cancer ☐ fatigue syndrome
EARS, NOSE, MOUTH, THROAT:	☐ hearing loss ☐ sinusitis ☐ dry mouth ☐ laryngitis
NEUROLOGICAL:	☐ multiple sclerosis ☐ epilepsy ☐ cerebral palsy ☐ tumor ☐ stroke ☐ migraine ☐ autism
PSYCHIATRIC:	☐ depression ☐ attention deficit ☐ anxiety disorder ☐ bipolar disorder
CARDIOVASCULAR:	☐ hypertension ☐ stroke ☐ heart disease ☐ vascular disease ☐ congestive heart failure
RESPIRATORY:	☐ smoker ☐ asthma ☐ bronchitis ☐ emphysema ☐ chronic obstruction ☐ sleep apnea
GASTROINTESTINAL:	☐ crohn's ☐ colitis ☐ ulcer ☐ acid reflux ☐ celiac disease
GENITOURINARY:	☐ kidney disease ☐ prostate disease ☐ std ☐ pregnant ☐ nursing ☐ herpes ☐ chlamydia
MUSCULOSKELETAL:	☐ arthritis ☐ fibromyalgia ☐ muscular dyst. ☐ ankylosing spondylitis ☐ osteoporosis ☐ gout
INTEGUMENTARY:	☐ eczema ☐ rosacea ☐ psoriasis ☐ cold sores ☐ shingles
ENDOCRINE:	☐ type 2 diabetes ☐ type 1 diabetes ☐ thyroid dysfunction ☐ hormonal dysfunction
HEMATOLOTIC/LYMPHATIC	☐ anemia ☐ large-volume blood loss ☐ ulcer ☐ hypercholesteremia
ALLERGY:	☐ drug allergies ☐ environmental allergies ☐ rheumatoid arthritis ☐ lupus ☐ sjogren's

Please Specify any other **Medical Conditions** not listed above:

Do you wear Contact Lenses? ☐No ☐Yes What solution do you use? _____

If yes, what brand? _____ and power? Right:_____ Left:_____

Please rate on scale of 1 (poor) to 10 (best): Lens Comfort: _____ Vision: _____ Near Vision: _____

Please specify below any other concerns you'd like us to go over today: