MEDICAL HISTORY QUESTIONNAIRE:

Name:____ Date of Last Eye Exam____/____/____ Date____/_____/_____

ESTABLISHED PATIENT'S ONLY: If there are no changes with the information below, intitial her and skip this page

Medications Currenly taken (include over-the counter & herbals):____

____ ________

Allegies to Medication: Y N If Yes, list mediations: ____

List any Surgeries you have had:____

____

Check any of the following that you currently have or have a history of : ______ Cataract _______ Macular Degeneration

___ Glaucoma/suspect ___ Retinal Hole/Detachment ___ Strabismus/amblyopia (lazy eye) ___ Patching ___ Keratonconus

___ Eye Injury ____ Eye Surgery: ___ Cataract ___ PRK/LASIK ____ Glaucoma ____ Diabetic Retinopathy___EyeMuscle ___ Lid

REVIEW OF SYSTEMS: *Please circle any of the following problems you have had*

Eyes	Dry Eye Floaters (new) Flashes of light	Redness Burning Itching	Tearing Discharge Blurred Vision	Eye Strain/Pain Light Sensitivity Headache (new?)	Poor Night Vision Night Glare Double/Loss of Vision
Constitution	Developmental Disabilities	Cancer: Type__________________	Fatigue Syndrome	Other	
ENT	Hearing Loss	Sinustis	Dry Mouth	Laryngitis	Other
Neurological	Multiple Sclerosis	Eplepsy	Autism	Cerebral Palsy	Tumor Stroke Migraine
Psychiatric	Depression	Attention Deficit	Anxiety Disorder	BiPolar Disorder	Other
Cardiovascular	Hypertension	Heart Disease	Vascular Disease	Congestive Heart Failure	Other
Respiratory	Cigarette Smoker	Asthma	Bronchitis	Emphysema	COPD Sleep Apnea Other
Gastrointestinal	Crohn's	Colitis	Ulcer	Acid Reflux	Celiac Disease IBS Other
Genitourinary	Kidney Disease	Prostate Cancer	STD-Herpes/ Chlamydia	Benign Prostate	Pregnant Nursing current only
Musculoskeletal	Osteoarthritis Osteoporosis	Arthritis Gout	Fibromyalgia	Muscular Dystrophy	Ankylosing Spondylitis Other
Integumentary	Eczema	Rosacea	Psoriasis	Cold Sores	Shingles: Location____________ Other
Endocrine	Diabetes Type 2	Diabetes Type 1	Thyroid Disorder	Hormonal Dysfunction	Other
Blood/Lymphatic	Anemia	High Cholesterol	Large Volume Blood Loss		Other
Allegic/Imm	Enviromental Allergies	Rheumatoid Arthritis	Lupus	Sjogren's Syndrome	HIV Other

SOCIAL HISTORY:

Does your vision limit any activities (driving, reading, sports, work, etc.)? Y N

Do you drink alcohol Y N If yes, how much? ____________________________

Do you smoke? Y N If yes, how much? ____________________________

Family History	**Cancer**	**Diabetes Type 1**	**Diabetes Type 2**	**Hyper-tension**	**Hyper-thyroid**	**Hypo-thyroid**	**Cataract**	**Macular Degener-ation**	**Glaucoma**
Father									
Mother									
Brother									
Sister									
Child									

Family Histo	Cancer	Diabetes T	Diabetes T	Hypertens	Hyper-thy	Hypo-thyr	Cataract	Macular D
Father								
Mother								
Brother								
Sister								
Child								

Family History	**Cancer**	**Diabetes Type 1**	**Diabetes Type 2**	**Hyper-tension**	**Hyper-thyroid**	**Hypo-thyroid**	**Cataract**	**Macular De**
Father								
Mother								
Brother								
Sister								
Child								

Glaucoma	
Glaucoma	