Eye Care

Medical History Questionnaire

Patient's Name:________________________________ Date: ________________

Reason for visit/Current problem:________________________________

Please answer the following questions to the best of your knowledge.

Date of last eye exam: ________________

Do you currently wear glasses? ☐ No ☐ Yes

Do you currently wear contact lenses? ☐ No ☐ Yes

Are you interested in trying contact lenses: ☐ No ☐ Yes

If so, would you like (check all that apply): ☐ Daily ☐ Weekly ☐ 2-Week ☐ Monthly ☐ Color

PATIENT OCULAR HISTORY: *Do you have any of the following conditions?*

Itching Eyes	☐ No	☐ Yes	Poor Color Vision	☐ No	☐ Yes	Light Sensitivity	☐ No	☐ Yes
Double Vision	☐ No	☐ Yes	Poor Night Vision	☐ No	☐ Yes	Floaters	☐ No	☐ Yes
Watery Eyes	☐ No	☐ Yes	Dry Eyes	☐ No	☐ Yes	Amblyopia/Lazy Eye	☐ No	☐ Yes

Eye Injury/Surgery *(if yes, please explain)* ☐ No ☐ Yes ________________________________

PATIENT/FAMILY MEDICAL HISTORY: *Is there a history of any of the following conditions?*

Please indicate relationship to patient: **S** = Self **M** = Mother **F** = Father **B** = Sibling **G** = Grandparent

Cataracts	☐ No	☐ Yes ________	Diabetes	☐ No	☐ Yes ________
Glaucoma	☐ No	☐ Yes ________	High Blood Pressure	☐ No	☐ Yes ________
Macular Degeneration	☐ No	☐ Yes ________	Thyroid Problems	☐ No	☐ Yes ________
Cancer *(if yes, list type)*	☐ No	☐ Yes ________	Other: ________________		

Please list any current prescription or over the counter medications you are taking.

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Do you have any allergies to medications? ☐ No ☐ Yes ________________________________

REVIEW OF SYSTEMS: *Do you have any of the following problems? If yes, please explain.*

- **Constitutional problems** *(appetite changes, obesity, fatigue, chills/fever)* ☐ No ☐ Yes ________________
- **Gastrointestinal problems** *(heartburn, abdominal pain)* ☐ No ☐ Yes ________________
- **Neurologic problems** *(headaches, migraines, seizures, numbness)* ☐ No ☐ Yes ________________
- **Skin problems** *(eczema, rosacea, rashes, excessive dryness)* ☐ No ☐ Yes ________________
- **Urinary problems** *(pain or discomfort, blood in urine)* ☐ No ☐ Yes ________________
- **Musculoskeletal problems** *(arthritis, muscle aches, joint pain)* ☐ No ☐ Yes ________________
- **Head/Ear/Nose/Throat problems** *(hearing loss, sinus problems, sore throat)* ☐ No ☐ Yes ________________
- **Endocrine problems** *(diabetes, thyroid, hormone disorders)* ☐ No ☐ Yes ________________
- **Cardiovascular problems** *(chest pain, heart problems, stroke)* ☐ No ☐ Yes ________________
- **Respiratory problems** *(asthma, wheezing, difficulty breathing)* ☐ No ☐ Yes ________________
- **Psychiatric problems** *(depression, anxiety, trouble sleeping)* ☐ No ☐ Yes ________________
- **Allergic/Immunologic problems** *(seasonal allergies, lupus, HIV)* ☐ No ☐ Yes ________________
- **Blood/Lymph problems** *(anemia, cholesterol problems)* ☐ No ☐ Yes ________________

Do you smoke? ☐ No ☐ Yes *(amount)* ____________ Drink alcohol? ☐ No ☐ Yes *(amount)* ____________

Use other substances/drug use? ☐ No ☐ Yes *(amount)* ____________ Do you drive?____________

OPTIONAL: *Certain ethnic groups are more at risk for different eye conditions. Which of the following best identifies you?*

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ White

☐ Native Hawaiian/Pacific Islander ☐ Other: ________________________ ☐ Prefer not to answer

☐ Doctor Reviewed: ________________________________ Date:________________