Mercy Clinic Eye Specialists
621 S. New Ballas Rd. | Suite 1001B
St. Louis, MO. 63141
314-251-5300 | Fax 314-251-5350

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

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.

_____

_____

_____

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

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

- **Ear/Nose/Throat problems** (*hearing loss, sinus problems)* ☐ No ☐ Yes _____
- **Cardiovascular problems** *(chest pain, heart problems, stroke)* ☐ No ☐ Yes _____
- **Respiratory problems** (*asthma, wheezing, difficulty breathing)* ☐ No ☐ Yes _____
- **Gastrointestinal problems** (*heartburn, abdominal pain)*
- **Urinary problems** *(pain or discomfort, blood in urine)* ☐ No ☐ Yes _____
- **Skin problems** *(eczema, rosacea, rashes, excessive dryness)* ☐ No ☐ Yes _____
- **Musculoskeletal problems** *(arthritis, muscle aches, joint pain)* ☐ No ☐ Yes _____
- **Neurologic problems** *(headaches, migraines, seizures, numbness)* ☐ 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: _____