



**Medical History Questionnaire**

**FAMILY/PERSONAL HISTORY**

***What problems are you currently having with your eyes? Circle all that apply:***

Blurred Vision	Redness	Distorted vision/halos	Burning
Itching	Loss of side vision	Foreign Body Feeling	Chronic lid infection
Dryness	Loss of central vision	Sandy or gritty feeling	Flashes/floating spots
Double Vision	Tired Eyes	Glare/light sensitivity	
Watering Excessively	Eye Pain or soreness	Crusting on eyelashes	

***Do you have any of the following eye conditions? Circle all that apply:***

Blindness	Diabetic Eye Disease	Macular Degeneration	Retinal Detachment
Glaucoma	Cataracts	Amblyopic (lazy eye)	Retinal Disease

***Do any blood relatives have any of the following eye or medical conditions? Circle all that apply:***

Blindness	Glaucoma	Diabetic Eye Disease	Cataracts
Macular Degeneration	Amblyopic (lazy eye)	Diabetes	High Blood Pressure
Cancer	Thyroid Disease	Retinal Disease	Retinal Detachment

Other: \_\_\_\_\_

**REVIEW OF SYSTEMS**

***Do you have any of the following medical conditions? Circle all that apply***

Headaches	Allergies/hay fever	Asthma	Diabetes	Migraine
Sinus congestion	Chronic Bronchitis	Heart/Chest pain	Bleeding Disorder	Runny Nose
Emphysema	High Blood Pressure	Stroke/Seizures	Cancer	Fever, weight loss/gain
Chronic cough	Arthritis	High Cholesterol	Thyroid Disease	Diarrhea/constipation
Dry throat/mouth	Fibromyalgia	Psoriasis/rosacea	Lupus	Depression
Heart Disease	Kidney/Bladder Disease			

Other: \_\_\_\_\_

**SOCIAL HISTORY**

***Please answer the following: Circle Answer:***

Do you drive?	Yes	No		
Do you consume alcohol?	Yes	No		
Do you use tobacco products?	Yes	No		
Are you a carrier of, or infected with:	Hepatitis	HIV	Gonorrhea/Syphilis	None

**MEDICAL HISTORY**

Please list all medications you are taking:

\_\_\_\_\_

When was your last physical exam?

\_\_\_\_\_

Are you pregnant?                      Yes                      No

Are you allergic to any medications?      Yes (please List)

\_\_\_\_\_

List all major surgeries or injuries you have in the past 10 Years.

\_\_\_\_\_