

**Medical Eye Examination
Patient History Questionnaire**

Name: _____ Date: _____
(Last) (First) (MI)

Occupation: _____ Employer: _____

If an eye doctor suggested you see us, please provide the doctor's name: _____

What bothers you most about your current vision and how it impacts your quality of life?

List activities and hobbies that you enjoy: _____

Have you had any other second opinions about your vision? Yes No

If yes, please provide the names of the other doctor(s):

What questions do you have that we could address during your consultation?

Medical and Eye History

List all **eye surgeries** you have had:

	Type of Surgery	Which Eye	Surgeon's Name	Date
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____

List all **eye injuries or diseases** you have had (glaucoma, cataract, etc.):

List all **eye drops** you use, which eye, and how often you use them:

List any **medications** you currently take (Rx and over-the-counter):

List any medications you are **allergic** to:

List all **major illnesses** (diabetes, high blood pressure, heart attack, etc.):

If female, are you or might you be pregnant?

Yes No

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (growths, rashes, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)?

Blindness, Keratoconus, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Do you drink alcohol?.....YES NO If YES, how much? _____

Do you smoke?.....YES NO If YES, how much? _____ How many years? _____

Physician's Signature _____

Date _____