MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________ **DOB:** ______________

Pharmacy: ______________________

Location: ______________________

Are you allergic to any medications? ☐ No ☐ Yes **Sulfa** **Penicillin**

List others: ______________________

PAST EYE HISTORY

Do you currently take any eye drops? ☐ No ☐ Yes **Please list eye drops below :**

Name of Drop	Dosage	How taken

Do you have any allergies to eye drops? ☐ Yes ☐ No List: ______________

History of cataract, glaucoma ☐ Yes ☐ No ______________

History of crossed/lazy eye ☐ Yes ☐ No ______________

Eye injury or other trauma ☐ Yes ☐ No ______________

Eye disease(s) ☐ Yes ☐ No ______________

Eye surgery ☐ Yes ☐ No ______________

Do you wear contact lenses? ☐ Yes ☐ No Type: Soft Hard Gas Permeable

List major illnesses:

- ☐ Heart disease
- ☐ Anemia
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Cold hands/feet
- ☐ Arthritis
- ☐ Depression
- ☐ Blood transfusion
- ☐ Tuberculosis
- ☐ Epilepsy/Seizures
- ☐ Headaches/migraines
- ☐ Cancer/type: ______________
- ☐ Breathing problems/Asthma
- ☐ Previous head trauma
- ☐ Excessive weight loss/gain
- ☐ Kidney problems/stones
- ☐ HIV/AIDS
- ☐ Hepatitis A B C

Other: ______________________

List any major surgical procedures:

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Medical History Questionnaire Page 2

PAST MEDICAL HISTORY

Please list all medications that you are currently using:

Name of Medication	Dosage	How taken

Have you received any vaccinations this year: ☐ Pneumonia ☐ Influenza ☐ other:____________

FAMILY HISTORY

OCULAR	YES	NO	RELATIONSHIP
Blindness	☐	☐	____________
Cataract(s)	☐	☐	____________
Glaucoma	☐	☐	____________
Macular degeneration	☐	☐	____________
Retina detachment	☐	☐	____________
MEDICAL			
Diabetes	☐	☐	____________
Other (list)	☐	☐	____________

SOCIAL HISTORY

Do you drink alcohol? ☐ ☐ How much?____________

Smoking status ☐ Current smoker How much per day?__________ ☐ Former Smoker ☐ Never smoked

Do you now or have you ever used illegal drugs? ☐ YES ☐ NO List:____________

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If YES, give an explanation.

EYES	YES	NO	EXPLANATION OF PROBLEM
Loss or blurred vision	☐	☐	____________
Itching, burning, or discharge	☐	☐	____________
Redness	☐	☐	____________
Gritty feeling/dryness/tearing	☐	☐	____________
Glare/light sensitivity, or halos	☐	☐	____________
Infection of lids or styes	☐	☐	____________

Are any of the following activities difficult for you?

Driving ☐ Night vision ☐ Reading ☐ Daily activities ☐

____________________________________ ____________

PATIENT/GUARDIAN SIGNATURE **DATE**