

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____ Age _____

Name of Physician referring you _____ Physician Phone (____) _____

Physician Address _____ Date of last physical exam _____

REVIEW OF SYSTEMS Do you currently have any problems in the following areas? If "yes", please provide information in the space below.

Is your general health good? Yes No

CONSTITUTIONAL SYMPTOMS

	Yes	No	Explanation of problem.....
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

EYES

Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wandering eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine or frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating visual acuity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nystagmus (constant jerking of the eyes)	<input type="checkbox"/>	<input type="checkbox"/>	_____

EAR, NOSE, MOUTH & THROAT

Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____

RESPIRATORY

	Yes	No	Explanation of problem.....
Lungs/breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other lung problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

CARDIOVASCULAR

Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____

GASTROINTESTINAL

Stomach	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intestines	<input type="checkbox"/>	<input type="checkbox"/>	_____

GENITOURINARY

Genitals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder			_____

MUSCULOSKELETAL

Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____

INTEGUMENTARY

	<input type="checkbox"/>	<input type="checkbox"/>	_____
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NEUROLOGICAL

	<input type="checkbox"/>	<input type="checkbox"/>	_____
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PSYCHIATRIC

	<input type="checkbox"/>	<input type="checkbox"/>	_____
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ENDOCRINE

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____

HEMATOLOGIC/LYMPHATIC

Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	What type? _____

ALLERGIC/IMMUNOLOGIC

Allergy/Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes Zoster	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes Simplex	<input type="checkbox"/>	<input type="checkbox"/>	_____

(OVER)

PAST HISTORY

List any medications you/your child takes: _____

List all major illnesses and injuries including eyes: _____

List any surgeries you/your child has had including eyes: _____

Have you/your child had crossed eyes, wandering eyes, lazy eye, drooping eyelid, or prominent eyes? _____

Were you/your child born prematurely? Yes No If YES, how many weeks premature? _____

Was oxygen administered? Yes No If YES, for how long? _____

Was surgery required for eye problems due to premature birth? Yes No

If YES, what type of eye surgery was required? _____

Any other complications of birth? _____

Do you/your child have allergies to any medications? Yes No If YES, list medications: _____

FAMILY HISTORY

DISEASES	Yes	No	Relation to patient.	DISEASES	Yes	No	Relation to patient.	DISEASES	Yes	No	Relation to patient.
Low vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retin. Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nearsightedness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wandering eye	<input type="checkbox"/>	<input type="checkbox"/>	_____	Farsightedness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Astigmatism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____				

SOCIAL HISTORY

Current Occupation _____

Do you drive? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Do you wear contact lenses? Yes No

Have you ever tried to wear contacts? Yes No

Do you currently wear glasses? Yes No

If YES, how long have you had your current pair? _____

Do you drink alcohol? Yes No
If YES, how many glasses per day? _____

Do you smoke? Yes No
If YES, how many packs a day? _____

Have you ever had a blood transfusion? Yes No

Have you ever been in intimate contact with a person who had a sexually transmitted disease Yes No

Have you ever tested positive for?
Heptatis: Yes No
Tuberculosis: Yes No
HIV/AIDS: Yes No

Patient Signature or Parent of Minor Child _____ **Date** _____

