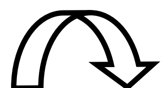
Patient Name: **DOB:**

MEDICAL HISTORY QUESTIONNAIRE

Date of **last eye exam**: ___________ Who is your family physician(s)?: ____

Have you ever been diagnosed with following?	YES	NO	Explanation of Problem
Cataract			
Age related macular degeneration			
Glaucoma			
Diabetes			
Diabetic retinopathy			
Dry eyes			
Floaters and/or flashes of light			
Retinal detachment			
Eye inflammation or infection			
Other:			
Check ALL Current Eye Symptoms	**YES**	**NO**	
Blurred vision (near or far)			
Halos around lights or glare with sun			
Dry eyes			
Redness or eye discomfort			
Itching			
Sticky eyes or discharge			
Tired eyes			
Other:			
Please Check YES or NO for the following:	**YES**	**NO**	
GASTROINTESTINAL Stomach ulcers, intestinal disease...etc			
GENITOURINARY Kidney, prostate, urinary tract...etc			
MUSCULOSKELETAL Arthritis, joint pain...etc			



CARDIOVASCULAR	YES	NO	Explanation of Problem
Angina/heart disease			
Elevated cholesterol/triglycerides			
High blood pressure			
Other:			
NEUROLOGICAL Multiple sclerosis, stroke, migraine...etc			
ENDOCRINE Diabetes, thyroid ...etc			
BLOOD/LYMPH Anemia, lymphoma, sickle cell..etc			
ALLERGIC/IMMUNOLOGIC Allergies, lupus, Sjogrens, hay fever...etc			
PSYCHIATRIC Depression, anxiety...etc			

Please provide any details concerning previous surgeries/treatments/hospitalizations if not mentioned above:

FAMILY HISTORY

M=Mother F=Father S=Sibling GP=Grandparent

DISEASE	YES	NO	Relationship to Patient
Macular Degeneration			
Glaucoma			
Diabetes			
Heart disease or high blood pressure			
Stroke			
Other:			

SOCIAL HISTORY

Current Occupation: ________________________________ Marital Status: __Married __ Divorced __ Single __ Widowed

Do you drink alcohol? __ Yes __ No If yes, how much? ____

Do you smoke? __ Yes __ No If yes, how much? ____

—Office Use Only Below This Point—

Technicians: **Exam Date:**

Patient Name: **DOB:**

MEDICATION QUESTIONNAIRE

Date of **last eye exam**: ___________ Who is your family physician(s)?: ____

PLEASE FILL IN ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS YOU TAKE

IF YOU HAVE A LIST ALREADY YOU MAY BRING THAT INSTEAD

PLEASE LIST ALL MEDICATIONS	DOSE/AMOUNT	FOR WHAT CONDITION DO YOU TAKE THIS?