

Name \_\_\_\_\_

Date **May 5, 2005**

## MEDICAL HISTORY QUESTIONNAIRE

### EYE HISTORY

- |                           |                          |                         |                          |                           |                          |
|---------------------------|--------------------------|-------------------------|--------------------------|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No | Headaches               | Blurred Vision Distance  | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Glare/Light Sensitivity | Blurred Vision Near      | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Tired Eyes              | Distorted Vision (halos) | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Lazy Eye                | Double Vision            | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Burning/ Itching        | Floaters or Spots        | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Dryness                 | Fluctuating Vision       | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Excess Tearing/Watering | Loss of Vision           | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Eye Pain or Soreness    | Loss of Side Vision      | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Foreign Body Sensation  | Drooping Eyelid          | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Infection of Eye or Lid | Redness                  | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Glaucoma                | Sandy or Gritty Feeling  | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No | Mucous Discharge        | Crossed Eyes             | <input type="radio"/> Yes | <input type="radio"/> No |

### GENERAL HEALTH CONDITION

- |                           |                          |                         |                           |                          |                                     |
|---------------------------|--------------------------|-------------------------|---------------------------|--------------------------|-------------------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No | Fever                   | <input type="radio"/> Yes | <input type="radio"/> No | Kidney                              |
| <input type="radio"/> Yes | <input type="radio"/> No | Heart dz, Stroke _____  | <input type="radio"/> Yes | <input type="radio"/> No | Arthritis                           |
| <input type="radio"/> Yes | <input type="radio"/> No | Liver, Hepatitis _____  | <input type="radio"/> Yes | <input type="radio"/> No | Skin                                |
| <input type="radio"/> Yes | <input type="radio"/> No | Ears, Nose, Throat      | <input type="radio"/> Yes | <input type="radio"/> No | Neurological (MS)                   |
| <input type="radio"/> Yes | <input type="radio"/> No | High blood pressure     | <input type="radio"/> Yes | <input type="radio"/> No | Anxiety, Depression, Insomnia _____ |
| <input type="radio"/> Yes | <input type="radio"/> No | Asthma, Emphysema _____ | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes                            |
| <input type="radio"/> Yes | <input type="radio"/> No | Gastrointestinal        | <input type="radio"/> Yes | <input type="radio"/> No | Blood/Lymph (cholesterol)           |
| <input type="radio"/> Yes | <input type="radio"/> No | Psychiatric             | <input type="radio"/> Yes | <input type="radio"/> No | Thyroid                             |

Past Illnesses or Injuries: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific Allergies: \_\_\_\_\_

Are you currently pregnant?  Yes  No

When was your last health exam? \_\_\_\_\_

### FAMILY HISTORY

- |                      |                           |                          |                     |                           |                          |
|----------------------|---------------------------|--------------------------|---------------------|---------------------------|--------------------------|
| Lazy Eye             | <input type="radio"/> Yes | <input type="radio"/> No | Arthritis           | <input type="radio"/> Yes | <input type="radio"/> No |
| Blindness            | <input type="radio"/> Yes | <input type="radio"/> No | Cancer              | <input type="radio"/> Yes | <input type="radio"/> No |
| Cataract(s)          | <input type="radio"/> Yes | <input type="radio"/> No | Diabetes            | <input type="radio"/> Yes | <input type="radio"/> No |
| Color Blindness      | <input type="radio"/> Yes | <input type="radio"/> No | Heart Disease       | <input type="radio"/> Yes | <input type="radio"/> No |
| Glaucoma             | <input type="radio"/> Yes | <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No |
| Macular Degeneration | <input type="radio"/> Yes | <input type="radio"/> No | Kidney Disease      | <input type="radio"/> Yes | <input type="radio"/> No |
| Retinal Detachment   | <input type="radio"/> Yes | <input type="radio"/> No | Lupus               | <input type="radio"/> Yes | <input type="radio"/> No |
| Eye Turn             | <input type="radio"/> Yes | <input type="radio"/> No | Stroke              | <input type="radio"/> Yes | <input type="radio"/> No |
| Others               | <input type="radio"/> Yes | <input type="radio"/> No | Thyroid Disease     | <input type="radio"/> Yes | <input type="radio"/> No |

List Below