

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of birth _____ Date of last eye exam _____

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

Do you have allergies to any medications? YES NO If YES, list the medications:

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.)

List any surgeries you have had (cataract, tonsillectomy, appendectomy):

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

EYES	YES	NO	Explanation of Problem
Loss of complete or side vision			
Blurred or Double vision			
Fluctuating or Distorted vision (halos)			
Dryness, Redness, Itching, or Burning			
Mucous discharge			
Sandy or gritty feeling			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes, Drooping eyelid			
Crossed eyes, lazy eye			
Glaucoma			
Cataract			
Retinal Detachment			
Macular Degeneration			
GENERAL HEALTH			
Fever			
Weight Loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

OVER PLEASE