

**MEDICAL HISTORY QUESTIONNAIRE**  
Adapted from the American Academy of Ophthalmology

**Name:** \_\_\_\_\_ **MR #:** \_\_\_\_\_

**Please circle**

**Date:** \_\_\_\_\_

**Patient's past eye history:**

Glasses	Contact Lenses	Cataract	Cataract surgery	Glaucoma	High eye pressure
Flashes	Floaters	Lazy eye	Crossed eyes	LASIK	Macular degeneration
Eye injury	Eye disease	Dry eye	Retinal problems	Diabetic retinopathy	Other _____

**Have you ever had?**

<b>No health problems</b>	Diabetes	High blood pressure	Cancer	Thyroid problems	Breathing problems
Rheumatoid arthritis	Sjogrens	Heart problems	Lupus	Other _____	

**Surgery?**

<b>None</b>	Heart surgery	Bypass	Stent	Pacemaker	Hysterectomy
Thyroidectomy	Gall bladder	Cancer surgery _____		Other _____	

**Drug allergies:**

<b>None</b>	Penicillin	Sulfa	Tetracycline	Mycins	Other _____
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**Eye medications:**

<b>None</b>	Drops for glaucoma	Drops for eye pressure	Allergy drops	Tear drops	Eye vitamins
Contact lens drops	Other drops/ ointments/ gels _____				

<b><u>Current prescriptions, over the counter medications, vitamins:</u></b>	<b>or See List</b> <input type="checkbox"/>	<b><u>Reason</u></b>
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

<b><u>Family Eye History</u></b>	<b>YES</b>	<b>NO</b>	<b><u>Family member with condition</u></b>
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____

***PLEASE  
Complete  
other side***

**Family Medical History**

**YES NO Family member with condition**

Diabetes	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	_____
Other	[ ]	[ ]	_____

**Please Circle**

**Social History**

Occupation: \_\_\_\_\_ Retired Single Married Divorced Widowed

Do you use: None Tobacco products Alcohol / Wine Illegal substances

**Review of Systems**

Do you **presently** have any problems in the following areas? If "YES," please explain.

	Yes	No	
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs, breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach, intestines)	[ ]	[ ]	_____
Musculoskeletal (muscles, joints)	[ ]	[ ]	_____
Skin	[ ]	[ ]	_____
Neurological (stroke)	[ ]	[ ]	_____
Psychiatric (depression, anxiety)	[ ]	[ ]	_____
Endocrine (diabetes, thyroid, breast)	[ ]	[ ]	_____
Hematologic (blood disorder, anemia)	[ ]	[ ]	_____
Immunologic (AIDS, HIV)	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Or

GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**OFFICE PERSONNEL ONLY**

History reviewed: Date: _____	[ ] No changes	[ ] Additions as noted	Tech: _____ M.D. _____
History reviewed: Date: _____	[ ] No changes	[ ] Additions as noted	Tech: _____ M.D. _____
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