The Eye Care Center
Medical History Questionnaire

Name:_____ Date:_____

DOB:_____

List any medications you are currently taking (prescription and non-prescription)

_____

_____

_____

Do you have any allergies to latex? YES NO

Do you have any allergies to any medications? YES NO

If yes, list the medications: _____

_____

_____

Ocular History:	Self	Family History
Glaucoma	Y/N	Y/N
Cataracts	Y/N	Y/N
Macular Degeneration	Y/N	Y/N
Diabetes	Y/N	Y/N
Dry Eye	Y/N	Y/N
Lazy Eye	Y/N	Y/N
Retina Detachments	Y/N	Y/N
Wandering Eye	Y/N	Y/N

Medical History:	Self	Family History
Diabetes Type 1	Y/N	Y/N
Diabetes Type 2	Y/N	Y/N
Date Diagnosed with Diabetes		_____
Hypertension	Y/N	Y/N
Heart Attack	Y/N	Y/N
CABG	Y/N	Y/N
Thyroid	Y/N	Y/N
Asthma	Y/N	Y/N
Rheumatoid Arthritis	Y/N	Y/N
Migraines	Y/N	Y/N
Stroke	Y/N	Y/N
Cancer	Y/N	Y/N
If yes, what type?	_____	

List all major surgeries and hospitalizations (cataract, appendectomy, etc…) _____

_____

Social History

Does your vision limit any of your daily living? (driving, reading, work, sports) YES NO

Do you drink alcohol? YES How much? _____

NO

Do you smoke? YES How much? _____

NO How long? _____

Do you currently have any problems in the following areas? If YES – please provide additional information

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc)			
GENERAL / CONSTITUTIONAL (fever, heat stroke weight loss, weight gain, unusually tired)			
EARS / NOSE / THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc)			
CARDIVASCULAR (**high blood pressure**, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL , KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (**diabetes**, thyroid, etc.)			
BLOOD / LYMPH (bleeding, choleserolemia, anemia, problems related to blood transfusions, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, MS, etc.)			

History reviewed (date)	No Changes noted by patient	Changes Listed here:	Reviewed by : (tech/dr)

Doctor Date Patient Date