DOWNSTATE HEALTH
PHYSICIANS

MEDICAL HISTORY QUESTIONNAIRE

Name _____ **Date**_____

Name of Pharmacy_____ **Phone #**_____

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, high blood pressure, heart attack) 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

	YES	NO	EXPLANTION OF PROBLEM
Eyes (glaucoma, cataract, retinal disease, etc)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/ watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

MEDICAL HISTORY QUESTIONAIRE

	YES	NO	EXPLANATION OF PROBLEM
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth)			
CARDIOVASCULAR (heart, vessels, etc)			
RESPIRATORY (asthma, emphysema, etc)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc)			
SKIN (acne, warts, skin cancer, etc)			
NEUROLOGICAL (Multiple sclerosis, etc)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc)			
BLOOD/LYMPH (cholesterolemia, anemia, etc)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus Sjogrens, etc)			

FAMILY HISTORY **M=MOTHER** **F=FATHER** **S=SIBLING** **GP=GRANDPARENT**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current Occupation: _____

Education: ☐ High School ☐ Vocational School ☐ College Degree

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Living Arrangements: _____

Do you drive? Yes No Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No Have you ever tried to wear contact lenses? Yes No

Do you currently wear contact lenses? Yes No If Yes, how long have you worn contact lenses? _____

Do you currently wear glasses? Yes No If Yes, how long have you had current prescription? _____

Do you drink alcohol? Yes No If Yes, ☐ occasional ☐ 1per day ☐ 2-3per day ☐ 4+ per day

Do you smoke? Yes No If Yes, ☐ occasional ☐ ½ pk per day ☐ 1 pk per day ☐ 1+ pk day

Have you ever had a blood transfusion? Yes No

History Reviewed No Changes Additions as noted above

Physician's Signature: _____ Date: _____ Time: _____