

PATIENT MEDICAL HISTORY QUESTIONNAIRE

(This form is designed to aid the doctor in identifying problems and risks)

Last Name _____ First Name _____ MI _____ Age _____ Today's Date _____

What is the main reason for today's visit? _____

Do you have any allergies to medications? (Y/N) If yes, list: _____

Current medications (RX or over the counter, including eye drops, vitamins, aspirin, or oral contraceptives):

Current and Past Eye and Vision History: Please answer each question. Circle **None** or **No** if does not apply.

Describe past eye injuries, surgeries, or infections (o None) _____

Do you wear **eyeglasses**? (Y/N) For what activities? (o Full-Time) _____

Do you wear **contacts**? (Y/N) Do you sleep in them? (Y/N) What type are they? _____ Solution _____

Are you interested in trying contact lenses? (Y/N) Are you interested in colored contact lenses? (Y/N)

If you wear contact lenses, are you satisfied with the vision and comfort? (Y/N)

Do you have?

Glaucoma (Y/N)	Cataracts (Y/N)	Macular Degeneration (Y/N)	Blurred Vision (Y/N)	Eye Irritation (Y/N)
Dry Eyes (Y/N)	Tearing (Y/N)	Light Sensitivity (Y/N)	Eye Inflammation (Y/N)	Sandy/Gritty Feeling (Y/N)
Flashes (Y/N)	Floaters (Y/N)	Fluctuating Vision (Y/N)	Loss of Vision (Y/N)	Double Vision (Y/N)
Redness (Y/N)	Burning (Y/N)	Mucus Discharge (Y/N)	Tired Eyes (Y/N)	Crossed Eyes (Y/N)
Eye Pain (Y/N)	Itching (Y/N)	Lazy Eye (Y/N)		

How long since your last eye exam? _____ **By Whom?** _____ **Were your eyes dilated?** (Y/N/don't know)

Name of Family Physician _____ **Date of Last Physical Exam** _____

Medical History: Please mark each box that applies to a condition for which you have been diagnosed. If none, mark **None**.

Allergic/Immunologic o NONE

Environmental allergies
 Lupus

Ear/Nose/Throat o NONE

Upper resp tract infection
 Hearing loss

Neurological o NONE

Multiple sclerosis o Migraines
 Epilepsy/seizures
 Headaches

Hematological o NONE

Anemia
 Leukemia
 Cancer

Cardiovascular o NONE

Heart disease
 Hypertension
 Stroke
 Vascular disease

Endocrine o NONE

Diabetes
 Thyroid dysfunction
 Hormone replacement

Psychiatric o NONE

Depression
 Panic disorder

Musculoskeletal o NONE

Fibromyalgia o Ankylosing spondylitis
 Osteoarthritis o Muscular dystrophy
 Rheumatoid arthritis

Respiratory o NONE

Asthma
 Bronchitis
 Emphysema

Gastrointestinal o NONE

Diarrhea
 Constipation

Constitutional o NONE

Weight loss/gain (unexplained)
 Fever

Other Conditions

Skin o NONE

Eczema/rosacea/psoriasis
 Skin cancers

Genitourinary o NONE

STD-herpetic, chlamydia
 Kidney/bladder

Family History: o I am adopted or do not know my family history (**Please mark for each condition that applies**).

Do you know of any blood-related family members with any of the following conditions? (Please list relation if applies)

<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Crossed eye/ lazy eye _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Cataract _____	<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Macular degeneration _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Retinal detachment _____		

Social/Occupational/Hobbies History:

Do you... (check box if yes)

<input type="checkbox"/> Participate in sports? Please list _____	<input type="checkbox"/> Spend time outdoors? How much? _____ hrs/week
<input type="checkbox"/> Use computers more than an hour a day?	<input type="checkbox"/> Have prescription sunglasses?
<input type="checkbox"/> Experience eyestrain working on the computer?	<input type="checkbox"/> Prefer not to wear glasses at times?
<input type="checkbox"/> Have interest in a "test drive" of the latest contact lens design?	<input type="checkbox"/> Want information on Laser Vision Correction Surgery?
<input type="checkbox"/> Have interest in non-surgical approach to vision correction?	<input type="checkbox"/> Have more than one pair of current prescription glasses?
<input type="checkbox"/> Have children at home?	<input type="checkbox"/> Have family members in need of eyecare?

- How long can you read before your eyes bother you or you get a headache? o NEVER _____
- What are your hobbies or pastimes (other than sports)? _____
- Do you use tobacco products? (Y/N) If yes, type/amount/how long _____
- Do you drink alcohol? (Y/N) If yes, type/amount/how long _____

Thank you,
Dr. Ulrich and Dr. Garn