Medical History Questionnaire

Patient Name: _____ Date: _____

Do you have any of the following problems?	YES	NO	If YES, please explain:
Ear/Nose/Throat (e.g. sinus problems, sore throat, ear infections)			
Heart (e.g. irregular heart beats, chest pain)			
Respiratory (e.g. wheezing, coughing, shortness of breath)			
Gastrointestinal (e.g. diarrhea, vomiting, heartburn)			
Urinary (e.g. pain or discomfort, blood in urine)			
Skin (e.g. rashes, dryness)			
Neurological (e.g. headaches, numbness)			
Psychiatric (e.g. hyperactive, anxiety, depression)			
Musculoskeletal (e.g. muscle aches, joint pain)			
Chronic fever, unexpected weight loss/gain, fatigue			
Have you ever been hospitalized?			
Current medications:			
Allergies:		Reviewing Doctor	Date

Patient History:

- Main Reason for examination: _____
- Other symptoms:
  - ☐ blurred vision ☐ headaches ☐ excessive rubbing/ blinking ☐ eye pain/ strain ☐ itching/ burning/scratching
  - ☐ droopy eye lid ☐ crossed eye ☐ lumps or swelling ☐ wandering eye ☐ light sensitivity
  - ☐ redness ☐ crusting/discharge ☐ lazy eye/ poor vision ☐ double vision ☐ head tipping/tilting/ turning
  - ☐ other: _____
- Eye History: _____
  Age of first exam Most recent exam Exam performed by
- Eye Treatment: ☐ glasses ☐ contact lenses ☐ bifocals ☐ patching ☐ surgery ☐ vision therapy / exercises
- School: _____
  grade learning disabilities reading difficulties
- Birth History: Premature? YES / NO If YES, how early? _____

Family History:

- Any medical diseases in your family (e.g. diabetes, high blood pressure, cancer, glaucoma)? YES / NO
  If YES, please explain: _____
- Family Ocular History:
  - ☐ lazy eye ☐ cataract ☐ astigmatism ☐ nearsightedness
  - ☐ eye misalignment ☐ color blindness ☐ retinal problems ☐ glaucoma
  - ☐ unsure ☐ other: _____

FOR OFFICE USE ONLY:

Referred By: Primary Care Doctor: