Medical History Questionnaire – Adult

Patient Name: ______________________________ Sex: _______ Age: ______ Date: __________

Referring Physician: ____________________ Address: ________________________________

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any **yes** answer.

Current Eye Problem: ____

____

Ocular History

Have you ever had any eye disease, surgery, or injury? No ☐ Yes ☐

If **yes to injury**, was it work-related? No ☐ Yes ☐

If **yes**, please describe including dates and the name of the doctor who treated you.

Date **Doctor** **Description**

____

_

____

____

Have you ever worn glasses or contact lenses? No ☐ Yes ☐

How old is your prescription? ____

Have you ever been told that you have amblyopia or "lazy eye"? No ☐ Yes ☐

Medical History

Have you ever had major surgery or been hospitalized for any reason? No ☐ Yes ☐

If **yes**, please describe: ____

Have you ever had any complications from anesthesia? No ☐ Yes ☐

If **yes**, please describe: ____

Family History:

*If **yes** to any section **below**, please explain relationship to patient on lines provided:*

Blindness	No ☐	Yes ☐	____________________
Cataract	No ☐	Yes ☐	____________________
Glaucoma	No ☐	Yes ☐	____________________
Macular Degeneration	No ☐	Yes ☐	____________________
Strabismus (Lazy Eye)	No ☐	Yes ☐	____________________
Diabetes	No ☐	Yes ☐	____________________
Heart Attacks	No ☐	Yes ☐	____________________
High Blood Pressure	No ☐	Yes ☐	____________________
Thyroid Disease	No ☐	Yes ☐	____________________

Social History:

Does your vision make it difficult for you to:

Read?	No ☐	Yes ☐
Write?	No ☐	Yes ☐
Drive?	No ☐	Yes ☐
Cook?	No ☐	Yes ☐
Sew?	No ☐	Yes ☐
Watch TV?	No ☐	Yes ☐
Work?	No ☐	Yes ☐

Do you:

Smoke?	No ☐	Yes ☐
Chew tobacco?	No ☐	Yes ☐
Drink alcohol?	No ☐	Yes ☐
Use drugs?	No ☐	Yes ☐

Do you have any allergies? No ☐ Yes ☐

If **yes**, please describe:____

What kind of reactions have you experienced? ______________________________

____

Medications

Please list any medication(s) including eye drops, which you are currently taking. List the amount or strength of the medication(s) and how frequently you take the medication(s).

Name of Medication	Amount Taken	Times Taken per Day	Which eye?

Review of Systems

Do you have any problem in the following areas? If **yes**, please explain.

Skin	No ☐	Yes ☐	____________
Head (Headaches)	No ☐	Yes ☐	____________
Ears, Nose, Throat, and Mouth	No ☐	Yes ☐	____________
Lungs/Breathing (TB)	No ☐	Yes ☐	____________
Heart (High Blood Pressure)	No ☐	Yes ☐	____________
Stomach/Intestines	No ☐	Yes ☐	____________
Genitals, Kidney, Bladder	No ☐	Yes ☐	____________
Bones, Joints, Muscles	No ☐	Yes ☐	____________
Neurologic System	No ☐	Yes ☐	____________
Lymph Nodes/Swelling	No ☐	Yes ☐	____________
Blood (HIV Positive, Hepatitis)	No ☐	Yes ☐	____________
Allergic, Immunologic	No ☐	Yes ☐	____________
Endocrine (Diabetes, Thyroid)	No ☐	Yes ☐	____________
Psychiatric	No ☐	Yes ☐	____________