

LOOKING GLASS EYE CENTER / MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Phone: _____

Reason for Today's exam: _____ Race: _____

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, diabetes, high blood pressure, heart attack, etc.) 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.

EYES	YES	NO	Explanation of Problem
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Drooping eyelid			
Double vision			
Dryness (itching, burning, sandy feeling)			
Mucous discharge			
Redness			
Crossed eyes, lazy eye			
Infection of eye or lid (blepharitis or styte)			
Glare / light sensitivity			
Foreign body sensation			
Excess tearing / watering			
GENERAL / CONSTITUTIONAL			
Diabetes			
Cataracts			
Glaucoma			
Thyroid Disease			
Heart Condition			
High Blood Pressure			
Retinal Disease			
Tuberculosis			
Hepatitis			
HIV			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth)			

Over, please...

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.)			
Endocrine (diabetes, hypo/hyper thyroid, etc.)			
Blood/Lymph (Cholesterolemia, anemia, etc.)			
Allergic/Immunologic (hay fever, lupus, Sjogrens, etc.)			
Psychiatric (anxiety, depression, insomnia)			

FAMILY HISTORY

M=Mother

F=Father

S=Sibling

GP=Grandparent

EYES	YES	NO	Explanation of Problem
Macular Degeneration			
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): _____

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

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? YES NO Occasional 1 per day 2-3/day 4+/day

Do you smoke? YES NO Occasional 1/2 pack/day 1 pack/day 4+ pack

Have you ever had a blood transfusion? YES NO

History reviewed? No changes Additions noted above

Physician's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____