MEDICAL HISTORY QUESTIONNAIRE
ADULT HISTORY

Complete EyeCare West
5141 W Broad St.
Ste 100
Columbus, Ohio
43228

Name ____

*Today's Date*_____ - _____ - ______

*Date of Birth*_____ - _____ - ______ *Date of Last Eye Exam* ______ - ______ - ______

*By Dr.*____

List any medications you currently take (prescription and over the counter):

____

____

Do you have any allergies to any medication? ***YES*** ***NO***

If YES, list the medications: ____

____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussions, etc.):

____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.):

____

____

Do you currently have any problems in the following areas? If "YES", please provide information:

EYES	*YES*	*NO*	*EXPLANATION OF PROBLEM*
Glaucoma			
Cataract			
Retinal disease (macular degeneration)			
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 the eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

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Do you currently have any problems in the following areas? If "YES", please provide information:

	YES	NO	EXPLANATION OF PROBLEM
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EAR, NOSE, THROAT *Sinus, ear infection, chronic cough, dry mouth, etc.*			
HEART AND BLOOD *(Heart, vessels, etc.)*			
LUNG *(Asthma, emphysema, etc.)*			
GASTROINTESTINAL *Stomach ulcers, intestinal disease, hepatitis*			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS *(Arthritis, etc,)*			
SKIN *(Acne, warts, skin cancer, etc.)*			
NEUROLOGICAL *(Stroke, MS, etc,)*			
PSYCHIATRIC *(Anxiety, depression, insomnia, etc.)*			
ENDOCRINE *(Diabetes, hypothyroid, etc.)*			
BLOOD/LYMPH *(High cholesterol, anemia, lymphoma, leukemia, etc.)*			
ALLERGIC/IMMUNOLOGIC *Hayfever, Lupus, Sjögrens, AIDS/HIV*			

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Any family history of eye disease? If so, please list:

DISEASE	*YES*	*NO*	*RELATIONSHIP TO PATIENT*
Blindness			
Glaucoma			
Macular Degeneration			
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: (single, married, divorced, widowed) ______________________________

Do you drive? ***YES*** ***NO***

Do you have visual difficulty when driving? ***YES*** ***NO***

Do you drink alcohol? ***YES*** ***NO***
If yes, ***occasional*** ***more than 4 / day***

Do you smoke? ***YES*** ***NO***

If yes, how much per day? ______________________ *When did you start?* ______________________

Have you ever had a blood transfusion? ***YES*** ***NO***

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