Garrett Eye Clinic

***COMPLETE** EYE CARE*

MEDICAL HISTORY QUESTIONAIRE

NAME _____ CHART # _____ DATE _____

DATE OF BIRTH _____ DATE OF LAST EYE EXAM _____

LIST ANY MEDICATIONS YOU CURRENTLY TAKE (PRESCRIPTION AND OVER THE COUNTER)

_____

_____

_____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? _____ YES _____ NO

_____

LIST ALL MAJOR ILLNESSES (GLAUCOMA, DIABETES, HIGH BLOOD PRESSURE, HEART ATTACK, ETC) OR INJURIES

_____

LIST ANY SURGERIES YOU HAVE HAD (CATARACT, TONSILLECTOMY, APPENDECTOMY)

_____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

PLEASE CHECK YES OR NO TO EVERY CONDITION.

CONDITION	YES	NO	EXPLANATION OF PROBLEM
EYES (GLAUCOMA, CATARACT, RETINAL DISEASE, ETC)			
LOSS OF VISION			
BLURRED VISION			
FLUCTUATION IN VISION			
DISTORTED VISION (HALOS)			
LOSS OF SIDE VISION			
DOUBLE VISION			
DRYNESS			
MUCOUS DISCHARGE			
REDNESS			
SANDY OR GRITTY FEELING			
ITCHING			
BURNING			
FOREIGN BODY SENSATION			
EXCESSIVE TEARING/WATERING			
GLARE OR LIGHT SENSITIVITY			
EYE PAIN OR SORENESS			
INFECTION OF EYE OR LID (BLEPHARITIS, STYE)			
TIRED EYES			
CROSSED EYES, LAZY EYE			
DROOPING EYELID			

FEVER			
WEIGHT LOSS			
OTHER			

SINUS, EAR INFECTION, CHRONIC COUGH, DRY MOUTH, ETC			

CONDITION	YES	NO	EXPLANATION OF PROBLEM
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)			
PSYCHIARTIC (ANXIETY, DEPRESSION, INSOMNIA)			
ENDOCRINE (DIABETES, HYPOTHYROID, ETC)			
BLOOD/LYMPH (CHOLESTEROLEMIA, ANEMIA, ETC)			
ALLERGIC/IMMUNOLOGIC (HAYFEVER, LUPUS, SJOGRENS,ETC)			

FAMILY HISTORY

M-MOTHER, F-FATHER, S-SIBLINGS, GP-GRANDPARENT

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
BLINDNESS			
GLAUCOMA			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE OR HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LUPUS			
STROKE			
THYROID DISEASE			
OTHER			

SOCIAL HISTORY

CURRENT OCCUPATION _____

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

DO YOU CURRENTLY WEAR CONTACT LENSES? _____ YES _____ NO

DO YOU CURRENTLY WEAR GLASSES? _____ YES _____ NO

IF YES, HOW LONG HAVE YOU HAD YOUR CURRENT GLASSES/CONTACT PRESCRIPTION? _____

_____

DO YOU DRINK ALCOHOL? __ YES __ NO IF YES ___OCCASIONAL ___1 PER DAY ___2-3 PER DAY___ 4+ PER DAY

DO YOU SMOKE? __ YES __ NO IF YES ___OCCASIONAL ___1 PER DAY ___2-3 PER DAY___ 4+ PER DAY

HISTORY REVIEWED. _____ NO CHANGES _____ ADDITIONS AS NOTED ABOVE

PHYSICIANS SIGNATURE _____ DATE _____

CHART # _____