



## DEER PENICK EYE CLINIC

### MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

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

Do you have any 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.	YES	NO	Details
<b>EYES</b>			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Dropping eyelid			
<b>GENERAL/CONSTITUTIONAL</b> (fever, weight loss, other)			
<b>EARS, NOSE, THROAT</b> (stuffy nose, ear ache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, etc.)			

(...continued) If YES, please provide information.	YES	NO	Details
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, etc.)			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, etc.)			
<b>SKIN</b> (pimples, warts, growth, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD/LUMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC/IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, etc.)			

**FAMILY HISTORY**

M- mother F=father S=Sibling 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: \_\_\_\_\_

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**

Do you currently wear contact lenses? **YES NO**

Do you currently wear glasses? **YES NO**

Do you drink alcohol? **YES NO** If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? **YES NO** If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_