

# MEDICAL HISTORY QUESTIONNAIRE

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Date of **Birth** \_\_\_\_\_

Date of **last eye exam** \_\_\_\_\_

List any **medications** your child currently takes (prescription and over-the counter): \_\_\_\_\_

Does your child have new allergies to any medications, since your last visit? **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 your child has had (cataract, tonsillectomy, appendectomy): \_\_\_\_\_

Does your child **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			
Drooping 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, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, etc.)			

<b>FAMILY HISTORY</b>			
	M = mother    F = father    S = sibling    GP = grandparent		
Disease	YES	NO	Relationship to Patient
Blindness			
<b>Glaucoma</b>			
<b>Arthritis</b>			
<b>Cancer</b>			
<b>Diabetes</b>			
<b>Heart disease or high blood pressure</b>			
<b>Kidney disease</b>			
<b>Lupus</b>			
Stroke			
Thyroid disease			
Other			

<b>SOCIAL HISTORY</b>									
Current occupation: _____									
Education (high school, vocational school, college degree): _____									
Marital status (married, divorced, single, widowed): _____									
Living arrangements: _____									
Does your child drive?				YES	NO				
Does your child have visual difficulty when driving?				YES	NO				
Does your child have problems with night vision?				YES	NO				
Have you ever tried to wear contact lenses?				YES	NO				
Does your child currently wear contact lenses?				YES	NO	If YES, how long? _____			
Does your child currently wear glasses?				YES	NO	If YES, how long have you had your current prescription? _____			
Does your child drink alcohol?		YES	NO	If YES:	occasional	1/day	2-3/day	4+/day	
Does your child smoke?		YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day	

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

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