# MEDICAL HISTORY QUESTIONAIRE

Heritage Eye Care 81 River Street Montpelier 802 223-3761

Name: _____ Today's Date: _____

Birth Date: _____ Last Eye Exam/Where: _____

Name of Medical Doctor: _____ Last Medical Exam: _____

Why are you here today? _____

**Medical History**

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain: _____

_____

List any major injuries, surgeries/hospitalizations you have had: _____

_____

List any eye problem/disease/surgery you have had: _____

_____

Pregnant or nursing? ❑ Yes ❑ No Wear glasses? ❑ Yes ❑ No (Including OTC readers)

If yes, how old is current glasses? _____ Age started wearing glasses? _____

Wear contact lenses? ❑ Yes ❑ No ❑ Soft ❑ Rigid If yes, when CL last replaced? _____

Type of contact lenses: ❑ Toric ❑ Multifocal Disposable : Daily Weekly Monthly Are they comfortable? ❑Yes ❑No

## Family History

| YES | NO | | RELATIONSHIP TO YOU (Circle) MGM=Maternal Grandmother; P= Paternal |
|---|---|---|---|
| ❑ | ❑ | Blindness due to disease | Who/ what disease? |
| ❑ | ❑ | Cataracts | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Retinal Disease | Who/ What disease? |
| ❑ | ❑ | Glaucoma | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Macular Degeneration | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Eye turn | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Rheumatoid Arthritis | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Diabetes | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Heart Disease | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | High Blood Pressure | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Kidney Disease | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Lupus | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Thyroid Disease | Father Mother Brother Sister MGM MGF PGM PGF |
| ❑ | ❑ | Other | |

**SOCIAL HISTORY** (This information is held strictly confidential)

Do you drive? ❑ Yes ❑ No If yes, do you visual difficulty when driving? ❑ Yes ❑ No If yes, describe:_____

_____

Do you use tobacco products? ❑ Yes ❑ No If yes, what, how much and how long:_____

Do you drink alcohol? ❑ Yes ❑ No If yes, what, how much and how long:_____

Do you use illicit drugs? ❑ Yes ❑ No If yes, what:

Have you ever been exposed or infection with: ❑ Hepatitis ❑ HIV ❑ Gonorrhea ❑ Syphilis

**REVIEW OF SYSTEMS**

Do you currently have or ever had a consistent problem in the following areas?

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | **CONSTITUTIONAL** | | | **EARS, NOSE ,MOUTH, THROAT** |
| ❑ | ❑ | Fever, Weight Loss/ Gain | ❑ | ❑ | Allergies/ Hay Fever |
| ❑ | ❑ | **SKIN** | ❑ | ❑ | Sinus Congestion |
| | | **NEUROLOGICAL** | ❑ | ❑ | Runny Nose |
| ❑ | ❑ | Headaches | ❑ | ❑ | Post-Nasal Drip |
| ❑ | ❑ | Migraines | ❑ | ❑ | Chronic Cough |
| ❑ | ❑ | Seizures | ❑ | ❑ | Dry Mouth/ Throat |
| | | **EYES** | | | **RESPIRATORY** |
| ❑ | ❑ | Blurred Vision | ❑ | ❑ | Asthma |
| ❑ | ❑ | Double Vision | ❑ | ❑ | Chronic Bronchitis |
| ❑ | ❑ | Distorted Vision/ Halos | ❑ | ❑ | Emphysema |
| ❑ | ❑ | Loss of Vision | | | **VASCULAR/ CARDIOVASCULAR** |
| ❑ | ❑ | Loss of Side Vision | ❑ | ❑ | Diabetes |
| ❑ | ❑ | Burning | ❑ | ❑ | Heart Pain/ Attack |
| ❑ | ❑ | Dryness | ❑ | ❑ | High Blood Pressure |
| ❑ | ❑ | Foreign Body Sensation | ❑ | ❑ | Vascular Disease (like Cholesterol) |
| ❑ | ❑ | Itching | ❑ | ❑ | **GASTROINTESTINAL** |
| ❑ | ❑ | Mucous Discharge | ❑ | ❑ | **GENITOURINARY** |
| ❑ | ❑ | Redness | | | **BONES/JOINT/MUSCLES** |
| ❑ | ❑ | Sandy/ Gritty Sensation | ❑ | ❑ | Joint Pain |
| ❑ | ❑ | Excess Tearing | ❑ | ❑ | Muscle Pain |
| ❑ | ❑ | Eye Infection | ❑ | ❑ | Rheumatoid Arthritis |
| ❑ | ❑ | Eye Pain/ Soreness | | | **LYMPATHIC/ HEMATOLOGICAL** |
| ❑ | ❑ | Flashes/ Floaters | ❑ | ❑ | Anemia |
| ❑ | ❑ | Glare/ Light Sensitivity | ❑ | ❑ | Bruising/ Bleeding Problems |
| ❑ | ❑ | Tired Eyes | | | **ALLERGIC/ IMMUNOLOGICAL** |
| | | **ENDOCRINE** | ❑ | ❑ | Auto-Immune Disease(like Lupus/Sarcoid) |
| ❑ | ❑ | Thyroid | ❑ | ❑ | Other |
| ❑ | ❑ | Other Glands | ❑ | ❑ | **PSYCHIATRIC** (Like Depression/Anxiety) |

**If you answered yes above, please explain below. Or if you have any condition not listed above, please explain below:**

_____

_____

_____

_____

_____

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