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
EYES			
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			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			

(continued) If YES, please provide information.	YES	NO	Details
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (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): ______________________________

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:* ____________________