Maryville Family Eye Clinic **Medical History Questionnaire**

Last Name: _____ Today's Date: _____

First Name: _____ Sex: ❒ male ❒ female

Address: _____ Date of Birth: _____

City: _____ Social Security: _____

State/Zip _____ Marital Status: _____

Day Time Phone: _____ Emp. Status: _____

Cell Phone: _____ Employer: _____

Email: _____ Occupation: _____

Referred By: ❒ Patient ❒ Professional Preferred Language:

Referred Name: _____ ❒ English ❒ Spanish Other: _____

Race: ❒ Asian ❒ African American ❒ Hispanic ❒ White _____ Communication Preference: ❒ Telephone ❒ Email

Ethnicity: ❒ Hispanic ❒ Hawaiian/Pacific Islander ❒ Other _____ Last Eye Exam: _____

PATIENT MEDICAL HISTORY

Have you had eye or laser surgery before? ❒ yes ❒ no If yes, which eye was operated on? ❒ left ❒ right ❒ both

If yes, why were you operated on? _____

List medication allergies or none? _____

List all drugs you are currently taking? (eye drops, herbs & vitamins)

Name	Dose (mg)	How Often	Name	Dose (mg)	How Often

Are you diabetic? ❒ Yes ❒ No If yes, how long? _____

Do you check your own blood sugar? ❒ Yes ❒ No If yes, how often? _____

What was your blood sugar this morning? _____ What was your last Hemoglobin A1C (3 mo. avg. blood sugar)? _____

Do you wear glasses? ❒ Yes ❒ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ Yes ❒ No If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ Yes ❒ No

Please describe your current eye problems: _____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Do you currently have any problems in the following areas?

	YES	NO		YES	NO		YES	NO		YES	NO
flashes/floaters in vision	❒	❒	sandy or gritty feeling	❒	❒	loss of side vision	❒	❒	lazy eye	❒	❒
excess tearing/watering	❒	❒	foreign body sensation	❒	❒	itching	❒	❒	crossed eyes	❒	❒
dryness	❒	❒	chronic infection of eye or lid	❒	❒	sties or chalazion	❒	❒	drooping eyelid	❒	❒
burning	❒	❒	cataracts	❒	❒	glaucoma	❒	❒	eye injury	❒	❒

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PATIENT SOCIAL HISTORY

Do you drink alcohol? ❒ Yes ❒ No If yes, how often?_____ How much?_____

Do you smoke, or have you ever smoked? ❒ Yes ❒ No Year started _____ Year quit _____

What tobacco do you use? ❒ Cigarettes ❒ Pipe ❒ Cigars ❒ Chewing tobacco ❒ Snuff ☐ None

Have you ever been exposed to or infected with? ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis ☐ None

Do you use illegal drugs? ❒ Yes ❒ No If yes, type/amount/how long: _____

Are you currently pregnant? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU	DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness	❒	❒	_____	Cancer	❒	❒	_____
Cataract	❒	❒	_____	Diabetes	❒	❒	_____
Crossed Eyes	❒	❒	_____	Heart Disease	❒	❒	_____
Glaucoma	❒	❒	_____	High Blood Pressure	❒	❒	_____
Macular Degeneration	❒	❒	_____	Kidney Disease	❒	❒	_____
Retinal Detachment/Disease	❒	❒	_____	Lupus	❒	❒	_____
Arthritis	❒	❒	_____	Thyroid Disease	❒	❒	_____

Other: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

	YES	NO
Constitutional		
fever, weight loss/gain	❒	❒
Neurological		
headaches	❒	❒
migraines	❒	❒
seizures	❒	❒
Endocrine		
thyroid/other glands	❒	❒
Allergic/Immunologic	❒	❒
Lymphatic/Hematologic		
anemia	❒	❒
bleeding problems	❒	❒
sickle cell disease	❒	❒
Bones/Joints/Muscles		
rheumatoid arthritis	❒	❒
muscle pain	❒	❒
joint pain	❒	❒
Psychiatric		
mental illness	❒	❒
depression	❒	❒
Integumentary (Skin)	❒	❒
Ear, Nose, Mouth, Throat		
allergies/hay fever	❒	❒
sinus congestion	❒	❒
runny nose	❒	❒
post-nasal drip	❒	❒
chronic cough	❒	❒
dry throat/mouth	❒	❒
Respiratory		
copd	❒	❒
asthma	❒	❒
chronic bronchitis	❒	❒
emphysema	❒	❒
Vascular/Cardiovascular		
heart pain	❒	❒
high blood pressure	❒	❒
vascular disease	❒	❒
Gastrointestinal		
diarrhea	❒	❒
constipation	❒	❒
Genitourinary		
prostate	❒	❒
genitals/kidney/bladder	❒	❒

Doctor Signature_____