

**ASSOCIATED EYE CARE
Medical History Questionnaire**

Patient name: _____ Date: _____
 Primary care provider name and address: _____

In a few words, what brings you in today? _____

SINCE THIS PROBLEM BEGAN, HAVE YOU HAD ANY OF THE FOLLOWING?

Seasonal allergies _____	Vomiting _____	Headaches _____
Hay fever _____	Stomach ulcers _____	Migraines _____
Chest pain _____	Diarrhea _____	Paralysis _____
Congestive heart failure _____	Blood in stool _____	Joint aches _____
Irregular heart rhythm _____	Genital ulcers _____	Muscle aches _____
Fever _____	Urinary or genital discharge _____	Cough _____
Weight loss (unintended) _____	Kidney stones _____	Bronchitis _____
Rash _____	Blood in urine _____	Shortness of breath _____
Skin problems _____	Sinus problems _____	Asthma attack _____
	Post-nasal drip _____	Wheezing _____
	Runny nose _____	
	Dry mouth _____	
	Hearing loss _____	

Please list any other symptoms not listed above: _____

EYE HISTORY

Do you have, or have you ever been treated for, any of the conditions listed below?

Condition	Yes	Condition	Yes
Dry eyes	_____	Retinal detachment	_____
Macular degeneration	_____	Keratoconus	_____
Glaucoma	_____	Lazy/crossed eye	_____
Cataracts	_____	Uveitis/iritis	_____

Do you wear glasses? Yes No For reading, distance, or both? _____

How old are your eyeglasses? _____

Have you ever had eye surgery, including LASIK or other refractive surgeries, or an eye injury? Yes No

If yes, please list your eye surgeries and/or injuries and their dates: _____

Do you wear contact lenses? Yes No Do you sleep in them? Yes No

What kind are they? _____ How old are they? _____

Please complete opposite side.

MEDICAL HISTORY

Do you have, or have you ever been treated for, any of the conditions listed below?

Condition	Yes	Condition	Yes	Condition	Yes
High blood pressure	___	Type 1 diabetes	___	Sleep apnea	___
Heart problems	___	Type 2 diabetes	___	Blood disorder	___
Osteoarthritis	___	LDL	___	Skin problems	___
Rheumatoid arthritis	___	Stomach ulcers	___	Autoimmune disease	___
COPD/emphysema	___	Cancer	___	Migraines	___
Asthma	___	Kidney problems	___	Tuberculosis	___
Stroke	___	Stroke	___	HIV	___
Thyroid problems	___	Migraines	___		

If you have diabetes, what was your last hemoglobin A1c? ___

What is your usual fasting blood sugar? ___

Please list any other health problems not listed above: _____

Please list any surgeries you have had and their dates: _____

Have you had a flu vaccine this year? Yes No, for medical reasons No, for non-medical reasons

Have you had a pneumonia vaccine this year? Yes No, for medical reasons No, for non-medical reasons

CURRENT MEDICATIONS

Please list all medications you currently take, including any supplements: _____

ALLERGIES AND MEDICATION INTOLERANCES

Please list any allergies and medication intolerances, as well as the reactions you experience: _____

SOCIAL HISTORY

Do you currently smoke? Yes No

If yes, what and how much do you smoke? _____

At what age did you start smoking? _____

If no, are you a former smoker? Yes No At what age did you quit smoking? _____

Does anyone in your immediate family smoke? Yes No If yes, who? _____

How often do you drink alcohol? Daily Weekly Several times a month Never Type: _____

FAMILY MEDICAL HISTORY

Have any of your blood relatives had or been treated for any of the following conditions?

Condition	Yes	Relationship	Condition	Yes	Relationship
High blood pressure	___	_____	Dry eyes	___	_____
Heart problem	___	_____	Macular degeneration	___	_____
Osteoarthritis	___	_____	Glaucoma	___	_____
Rheumatoid arthritis	___	_____	Cataracts	___	_____
Lung problems	___	_____	Retinal detachment	___	_____
Stroke	___	_____	Keratoconus	___	_____
Thyroid problems	___	_____	Lazy/crossed eye	___	_____
Diabetes	___	_____			
High cholesterol	___	_____			
Stomach ulcers	___	_____			
Cancer	___	_____			