



CHELSEA *eye care*

205-678-2565

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Date of Last Exam: _____

List all medications, including non-prescription, you currently take. If you cannot remember the name you may list the reason for the medication (i.e. "blood pressure", "hormones", "vitamin E", etc):

Do you have any drug allergies? Yes No If yes, please list: _____

Are you currently experiencing (or have you previously experienced) any problems in the following areas?

If yes, please explain.

EYES (GENERAL): Yes No _____

BLURRED VISION: Yes No _____

BURNING: Yes No _____

DOUBLE VISION: Yes No _____

DRYNESS: Yes No _____

EYE PAIN: Yes No _____

FOREIGN BODY SENSATION: Yes No _____

ITCHING: Yes No _____

LOSS OF VISION: Yes No _____

REDNESS: Yes No _____

SWOLLEN EYE LIDS: Yes No _____

CARDIOVASCULAR: Yes No _____

HYPERTENSION: Yes No _____

DIABETES: Yes No _____

THYROID: Yes No _____

OTHER ENDOCRINE: Yes No _____

HAYFEVER / ALLERGIES: Yes No _____

SINUSITIS: Yes No _____

EAR / NOSE / THROAT: Yes No _____

ASTHMA / COPD / RESPIRATORY: Yes No _____

HEADACHE / MIGRAINE: Yes No _____

MUSCLES / BONES / JOINTS: Yes No _____

AUTO IMMUNE: Yes No _____

SJOGREN'S SYNDROME: Yes No _____

GASTROINTESTINAL: Yes No _____

KIDNEY / BLADDER / REPRODUCTIVE: Yes No _____

NEUROLOGICAL: Yes No _____

/ OTHER PSYCHIATRIC: Yes No _____

SKIN: Yes No _____

CANCER: Yes No _____

GENERAL (FATIGUE, FEVER, WEIGHT LOSS, ETC): _____

OTHER: _____

Are you currently pregnant or nursing? Yes No

Have you ever had a blood transfusion? Yes No

FAMILY HISTORY

Please indicate relationship of person to patient.

GLAUCOMA: _____ HYPERTENSION: _____

MACULAR DEGENERATION: _____ THYROID DISEASE: _____

DIABETES: _____ CANCER: _____

OTHER: _____

SOCIAL HISTORY

Current Occupation: _____ Marital Status: _____

Education (high school, college, trade school, etc): _____

Do you live in a nursing home or assisted living facility? Yes No Where? _____

Do you wear contact lenses? Yes No What type? _____ How long? _____

Do you drink? Yes No If yes, how much per day? _____

Do you smoke? Yes No If yes, how much per day? _____

Reviewed By: _____ Date: _____