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: _____

_____

List any surgeries you have had: _____

_____

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: _____