Chart#_____ MEDICAL QUESTIONNAIRE / EYE HISTORY

Month Day Year Page# _____

NAME: Birth Date ____/____/____ Age _____

PRESENT EYE HISTORY. Chief eye complain?

Duration of this problem?_____Chronic ? ☐YES ☐NO Progressive? ☐YES ☐NO

Check or mark with an X if you have any of these **eye symptoms**: Black spots☐Light flashes☐ Shadows☐
Loss of vision☐ Blurred vision☐ Distorted vision (halos)☐Loss of side vision ☐ Double vision☐
Headaches☐ Fluctuating visual acuity☐ Dryness☐ Eye discharge ☐ Redness ☐ Itching ☐
Sandy or gritty feeling ☐ **Sinusitis** ☐ Burning ☐ Foreign body sensation ☐ Tearing ☐ Tired eyes☐
Glare/light sensitivity ☐ Eye pain ☐ Sties, Cyst, Lumps ☐

If **X**,
explain (How long , etc)

PAST EYE HISTORY. Date last eye exam ? _____ Where or Eye Doctor ? _____

Do you wear **glasses**? _____If **YES**, last time changed ?_____Are you **considering contact lenses**?_____
Do you wear **contact lenses**?_____ If **YES**, last time changed?_____Daily wear?____ Extended wear? _____
Color lenses? ___ Any **eye diseases**? ___If **YES**, name ? _____Cataracts?_____Glaucoma? _____
Infections?____ Allergies? ___
Any **eye surgeries**? Yes ☐ No ☐ If **Yes**, type of surgery, when, where, surgeon ? _____

If you use **eye medications**,
Which ones ?

MEDICAL AND SOCIAL HISTORY. Your family doctor's name? _____City?_____

Do you **smoke**? Yes ☐ No ☐ Drink alcohol ? Yes ☐ No ☐ **Occupation:** _____**Student**? Yes ☐No☐

List ALL **systemic medications** presently taking (**diet pills** ?)

Allergies?

Other **general surgery** or **illness** or **hospitalization** ?

Who in your family has had: Diabetes- Cataracts- Glaucoma- Blindness- Macular degeneration-Hypertension- Heart attack- Stroke-Cancer-other

FAMILY HISTORY:

REVIEW OF SYSTEMS: Mark with an **X** if you have any of the following:

Fever☐ Weight Loss☐Gain weight☐Fatigue☐ Muscle aches☐ Joint pain☐Joint swelling ☐**Arthritis**☐Hearing loss☐
Noises tinnitus☐ Earaches☐ sinuses ☐ teeth/ gums problems☐Eczema ☐ Psoriasis ☐Skin rashes☐Heart attack☐
Palpitations ☐Chest pain ☐**Diabetes** ☐Thyroid ☐**High Blood Pressure**☐Aneurysm☐Clots ☐ Bruising ☐Low blood count☐ Asthma☐ Emphysema☐Wheesing☐Cough☐Numbness☐ Weakness☐ Paralysis☐ Stomach/ duodenal/ ulcers☐ Heartburn ☐Constipation☐ **Depression**☐ Anxiety ☐ Kidney Stones☐Bladder/ prostate problems ☐Urination problems☐ Remaining systems **WNL**____

If X explain,
How long and if receiving treatment:

Reviewed from ____/_____/ _____visit. **Changes Noted**: YES☐NO ☐

CHECKED BY _____(INI) _____**, M.D.** Date _____

Reviewed by Dr Mendoza__ Dr.Gonzalez__Dr. Gunzburgh