MARYLAND EYE
CONSULTANTS & SURGEONS

MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date_____

Date of **Birth**_____ Date of **last eye exam** _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.): _____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____

_____

_____

EYES	YES	NO	Details
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
Flashes of light			
Black spots			
Trouble seeing close			
Trouble seeing at a distance			
Previous injury to eye			

Have you ever tried to wear contact lenses? YES NO

Do you currently wear contact lenses? YES NO If YES, how long?_____

Do you currently wear glasses? YES NO If YES, how old is your current prescription?_____

Are you interested in LASIK/Refractive surgery? YES NO

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	YES	NO	Details
GENERAL/CONSTITUTIONAL (fever, weight loss, other)			
EAR, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY DISEASE	**YES**	**NO**	M=Mother F=Father S=Sibling GP=Grandparent
Blindness			
Glaucoma			
Arthritis			
Retinal detachment			
Macular degeneration			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Other			

SOCIAL HISTORY

Do you drive? YES NO

Do you have visual difficulty while driving? YES NO

Do you have problems with night vision? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? YES NO If YES: occasional 1/day 2-3/day 4+/day