CLARK EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Date of Birth: _____ Date of Last Eye Exam: _____

Primary Care Physician: _____ Physician's Phone: (____) _____

Physician's Address: _____

REVIEW OF SYSTEMS

Do You Currently Have **ANY** Problems In The Following Areas:

Eyes	YES	NO
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision (halos)	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Occasional Tearing	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sties, Chalazion	☐	☐
Fluctuating Visual Acuity	☐	☐
Tired Eyes	☐	☐
Crossed Eyes	☐	☐
Lazy Eye	☐	☐
Drooping Eyelid	☐	☐
Prominent Eyes	☐	☐
Constitutional Symptoms		
Fever	☐	☐
Weight Loss	☐	☐
Other	☐	☐

Ears, Nose, Mouth, Throat	YES	NO
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Cardiovascular (heart/blood vessels)	☐	☐
Respiratory (lungs/breathing)		
Chronic Bronchitis	☐	☐
Gastrointestinal (stomach/intestines)	☐	☐
Genitourinary (genitals/kidneys/bladder)	☐	☐
Musculoskeietal		
Muscle Pain	☐	☐
Joint Pain	☐	☐
Skin	☐	☐
Neurological	☐	☐
Psychiatric	☐	☐
Endocrine	☐	☐
Hematologic/Lymphatic		
Blood	☐	☐
Lymph Nodes	☐	☐
Swelling	☐	☐
Allergic/Immunologic		
Head Allergy Symptoms	☐	☐
Seasonal Allergies	☐	☐
Hay Fever Symptoms	☐	☐

If ***YES*** **t**o ***ANY*** of the Above, Explain _____

_____

_____

PAST HISTORY

List Any Medications You Take: _____

_____

List All Major Illnesses and Injuries: _____

_____

List Any Surgeries You Have Had: _____

_____

Are You Allergic To ANY Medications? ☐ YES ☐ NO

If YES, List Medications: _____

_____

(over, please)

FAMILY HISTORY

Have You Or Anyone In Your Family Had:

Disease	YES	NO	*Relationship To Patient*
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Attacks	☐	☐	_____
High Blood Presure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Sjogrens Syndrome	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Current Occupation _____

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 Tried To Wear Contacts? ☐ YES ☐ NO

Do You Currently Wear Glasses? ☐ YES ☐ NO
If Yes, How Long Have You Had The Current Pair? _____

Do You Drink Alcohol? ☐ YES ☐ NO
If Yes, How Many Glasses A Day?_____

Do You Smoke? ☐ YES ☐ NO
If Yes, How Many Packs a Day? _____
Have You Ever Had A Blood Transfusion? ☐ YES ☐ NO

Have You Ever Had Intimate Contact With A Person
Who Had A Sexually Transmitted Disease? ☐ YES ☐ NO

office use only

History Reviewed. ☐ No Change ☐ Additions As Noted Below

_____

Physician's Signature:_____ Date:_____