

MEDICAL HIS	STORY QUESTIONNAIRE:								
Name:									
ESTABLISHED PA	ATIENT'S ONLY: If there are no changes with the information below, intitial her and skip this page								
Medications Cur	rrenly taken (include over-the counter & herbals):								
	ication: Y N If Yes, list mediations:								
List any Surgerie	es you have had:								
Check any of the	e following that you currently have or have a history of : Cataract Macular Degeneration								
	suspect Retinal Hole/Detachment Strabismus/amblyopia (lazy eye) Patching Keratonconus								
	Eye Surgery: Cataract PRK/LASIK Glaucoma Diabetic Retinopathy EyeMuscle Lid								
	SYSTEMS: Please circle any of the following problems you have had								
	Dry Eye Redness Tearing Eye Strain/Pain Light Poor Night Vision								
	Floaters (new) Burning Discharge Blurred Sensitivity Headache Night Glare								
Eyes	Flashes of light Itching Vision (new?) Double/Loss of Vision								
Constitution	Developmental Disabilities Cancer: Type Fatigue Syndrome Other								
ENT	Hearing Loss Sinustis Dry Mouth Laryngitis Other								
Neurological	Multiple Sclerosis Eplepsy Autism Cerebral Palsy Tumor Stroke Migraine								
Psychiatric	Depression Attention Deficit Anxiety Disorder BiPolar Disorder Other								
Cardiovascular	Hypertension Heart Disease Vascular Disease Congestive Heart Failure Other								
Respiratory	Cigarette Smoker Asthma Bronchitis Emphysema COPD Sleep Apnea Other								
Gastrointestinal	Crohn's Colitis Ulcer Acid Reflux Celiac Disease IBS Other								
	Kidney Disease Prostate Cancer STD-Herpes/Chlamydia Benign Prostate Pregnant Nursing								
Genitourinary	current only								
	Osteoarthritis Arthritis Fibromyalgia Muscular Dystrophy Ankylosing Spondylitis Other								
Musculoskeletal	Osteoporosis Gout Fibromyalgia Muscular Dystrophy Ankylosing Spondylitis Other								
Integumentary	Eczema Rosacea Psoriasis Cold Sores Shingles: Location Other								
Endocrine	Diabetes Type 2 Diabetes Type 1 Thyroid Disorder Hormonal Dysfunction Other								
Blood/Lymphatic	Anemia High Cholesterol Large Volume Blood Loss Other								
Allegic/lmm	Enviromental Allergies Rheumatoid Arthritis Lupus Sjogren's Syndrome HIV Other								
SOCIAL HISTO	ORY:								
	Does your vision limit any activities (driving, reading, sports, work, etc.)? Y N								
	Do you drink alcohol Y N If yes, how much? Do you smoke? Y N If yes, how much?								

Family History	Cancer	Diabetes Type 1	Diabetes Type	Hyper- tension	Hyper- thyroid	Hypo- thyroid	Macular Degener- ation	Glaucoma
Father								
Mother								
Brother								
Sister								
Child								