NAME_____ ***MEDICAL HISTORY QUESTIONAIRE©2003***

Physician's Signature_____***Date:***_____ ☐ **History Reviewed**
☐ **No Changes**
☐ **Additions as noted**

SOCIAL HISTORY

CURRENT OCCUPATION_____**PREVIOUS**_____

Do you drive?	☐ yes ☐ No
Do you have visual difficulty when driving?	☐ yes ☐ No
Do you have problems with night vision?	☐ yes ☐ No
Do you Drink Alcohol?	☐ yes ☐ No

If YES, how often?_____

Do you Smoke?	☐ yes ☐ No

If YES, how many cigarettes/pack(s) a day_____

Have you ever had a blood transfusion?	☐ yes ☐ No
Do you currently wear glasses/contacts?	☐ yes ☐ No

If YES, how long have you had the current prescription?_____

HISTORY

List all major illnesses and injuries_____

List surgeries_____

Eye surgeries _____

_____

DETAILED EYE HISTORY

			Explanation of Problem
Loss of Vision	☐ yes	☐ No	_____
Blurred Vision	☐ yes	☐ No	_____
Distorted Vision (HALOS)	☐ yes	☐ No	_____
Double Vision	☐ yes	☐ No	_____
Dryness	☐ yes	☐ No	_____
Mucous Discharge	☐ yes	☐ No	_____
Redness	☐ yes	☐ No	_____
Sandy or gritty feeling	☐ yes	☐ No	_____
Itching	☐ yes	☐ No	_____
Burning	☐ yes	☐ No	_____
Tearing/ Watering	☐ yes	☐ No	_____
Glare/Light sensations	☐ yes	☐ No	_____
Eye pain or soreness	☐ yes	☐ No	_____
Styes, Chalazions	☐ yes	☐ No	_____

over