Eye Center OF LA JOLLA

Medical History Questionnaire

Patient Name:_____

Date of last eye exam:_____

Do you have any problems in the following areas? If yes, please explain

	No	Yes	COMMENTS
Eyes			
Loss of central vision	☐	☐	_____
Blurred vision	☐	☐	_____
Fluctuating vision	☐	☐	_____
Glare/Halos while driving at night	☐	☐	_____
Loss of side vision	☐	☐	_____
Double vision	☐	☐	_____
Have you ever had lazy (crossed) eyes?	☐	☐	_____
Other:_____			
Eye Pain/ soreness?	☐	☐	_____
Light sensitivity (pain due to light)?	☐	☐	_____
Sandy Feeling (Foreign Body Sensation)?	☐	☐	_____
Burning?	☐	☐	_____
Redness?	☐	☐	_____
Dryness?	☐	☐	_____
Discharge (mucus or crusting)?	☐	☐	_____
Tearing: occasional or always?	☐	☐	_____
Itching?	☐	☐	_____
Do you currently wear **Glasses** ?	☐	☐	_____
Contact Lenses ?	☐	☐	_____
If yes, is it for **DISTANCE**, **NEAR** or **BOTH?**			_____
How long have you had the current prescription?			_____
Have you ever had any eye surgeries or lasers?	☐	☐	_____
Do you use any eye drops? (Please list)	☐	☐	_____
			_____
			_____
Other:_____			
Family Eye History			
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Keratoconus	☐	☐	_____

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Review of Systems

	No	Yes	COMMENTS
Ears, Nose, Mouth, Throat			
Sinus congestion	☐	☐	_____
Runny nose	☐	☐	_____
Post nasal drip	☐	☐	_____
Chronic cough	☐	☐	_____
Fever?	☐	☐	_____
Weight Loss?	☐	☐	_____
Cardiovascular (heart attack? | high blood pressure?)	☐	☐	_____
Respiratory problems?	☐	☐	_____
Gastrointestinal problems? (stomach | colon)	☐	☐	_____
Genitourinary? (genitals | kidney | bladder)	☐	☐	_____
Musculoskeletal problems? (arthritis? Muscle | Joint)	☐	☐	_____
Integumentary problems? (skin and or breast)	☐	☐	_____
Neurological problems? Headaches?	☐	☐	_____
Psychiatric problems (anxiety/depression)**?**	☐	☐	_____
Endocrine? (thyroid, diabetes)	☐	☐	_____
Hematologic/Lymphatic			
Blood Disease (anemia, leukemia)?	☐	☐	_____
Have you ever had a blood transfusion?	☐	☐	_____
Allergic/ Immunologic			
Head allergy symptoms?	☐	☐	_____
Seasonal allergies?	☐	☐	_____
Hay fever symptoms?	☐	☐	_____
Social History			
Do you actively smoke (tobacco)? Quit?	☐	☐	_____
Do you drink alcohol?	☐	☐	_____
Do you do recreational drugs?	☐	☐	_____
Do you live alone?	☐	☐	_____
Do you work on the computer? Occupation?	☐	☐	_____
Have you ever had a sexually transmitted disease?	☐	☐	_____
Any other surgeries?	☐	☐	_____
Family History			
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Attack	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____
Tuberculosis	☐	☐	_____

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What is your Height?_____Weight?_____

List of Current Medications:

Allergies to Medicines? *(please list)*

Other:_____