Wichryk Eye Associates, P.C.

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Birth Date: _____ Date of last eye exam: _____

Review of Systems

Please check if you have or have had any of these:

Eyes
____ 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
____ Styes, Chalazion
____ Fluctuating visual acuity
____ Tired eyes

Ears, Nose, Mouth and Throat
____ Sinus congestion
____ Runny nose
____ Post-nasal drip
____ Chronic cough
____ Dry throat/mouth

Allergic/Immunologic
____ Head allergy symptoms
____ Seasonal allergies
____ Hay fever symptoms

Cardiovascular *(heart/blood vessels)*

Constitutional Systems
____ Fever
____ Weight loss
Other _____
_____

____ **Endocrine** *(diabetes, thyroid disease)*

____ **Gastrointestinal** *(stomach/intestines)*

____ **Genitourinary** *(genitals/kidneys/bladder)*

____ **Head**

Hematologic/Lymphatic
____ Blood
____ Lymph nodes Swelling

____ **Immunologic**

____ **Integumentary** *(skin)*

Musculoskeletal
____ Muscle pain
____ Joint pain

____ **Neurological**

____ **Psychiatric**

Respiratory *(lungs/breathing)*
____ Chronic bronchitis

Past History

List any medications you take
(including over-the-counter and vitamins):

1._____
2._____
3._____
4._____
5._____

List any surgeries you have had:

1. _____
2. _____
3. _____
4. _____
5. _____

List all major illnesses and injuries:

1._____
2._____
3._____
4._____
5._____

Any significant eye problems or eye injuries:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have allergies to any medications? ❑Yes ❑ No

If yes, which ones:_____

Social History

Do you wear contact lenses? ❑Yes ❑ No If yes,soft or gas permeable_____

Do you currently wear glasses? ❑Yes ❑ No If yes, what year were they made? _____

Do you drink alcohol? ❑Yes ❑ No If yes, how many glasses a day? _____

Do you smoke (including cigars)? ❑Yes ❑ No If yes, how many packs a day? _____

Have you ever had a blood transfusion? ❑Yes ❑ No

Have you ever been treated for a sexually transmitted disease? ❑Yes ❑ No

Family History

Please check all that apply:

Disease	Relationship
____ Blindness	_____
____ Cataract	_____
____ Glaucoma	_____
____ Macular degeneration	_____
____ Retinal detachment	_____
____ Arthritis	_____
____ Cancer	_____
____ Diabetes	_____
____ Heart attacks	_____
____ High blood pressure	_____
____ Kidney disease	_____
____ Lupus	_____
____ Sjogrens Syndrome	_____
____ Stroke	_____
____ Thyroid disease	_____
____ Tuberculosis	_____
____ Other	