Dr. Matthew R. Brown, O.D.
OPTOMETRIST

Medical History Questionnaire

Name: _____ Date: _____

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

CC: _____

_____

HPI: _____

_____

List any medications you currently take (prescription and over-the-counter):

_____

_____

_____

Do you have allergies to any medications: ❒ Yes ❒ No
If **yes,** list the medications:

_____

_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy):

_____

_____

_____

Do you **currently** have any problems in the following areas? If **yes,** please provide the information:

	Yes	No	Details
Eyes			
Loss of Vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision (Halos)			
Glare or Light Sensitivity			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			

	Yes	No	Details
Redness			
Sandy or Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing or Watering			
Eye Pain or Soreness			
Infection of Eye or Lid			
Tired Eyes			
Crossed Eyes, Lazy Eye			
Dropping Eyelid			

	Yes	No	Details
General / Constitutional (Fever, Weight Loss, etc.)			
Ears, Nose, Throat (Stuffy Nose, Earache, Cough, Dry Mouth, etc.)			
Cardiovascular (High Blood Pressure, Racing Pulse, etc.)			
Respiratory (Congestion, Wheezing, etc.)			
Gastrointestinal (Stomach Upset, Diarrhea, Constipation, etc.)			
Genital, Kidney Bladder (Painful Urination, Frequent Urination, Impotence, etc.)			
Muscles, Bones, Joints (Joint Pain, Stiffness, Swelling, Cramps, etc.)			
Skin (Pimples, Warts, Growths, Rashes, etc.)			
Neurological (Numbness, Headache, etc.)			
Psychiatric (Anxiety, Depression, Insomnia, etc.)			
Endocrine (Diabetes, Hypothyroid, etc.)			
Blood / Lymph (Cholesterolemia, Anemia, etc.)			
Allergic / Immunologic (Sneezing, Swelling, Redness, Itching, Hives, etc.)			

Family History

M=Mother F=Father S=Sibling G=Grandparent

	Yes	No	Relationship to Parent
Disease			
Arthritis			
Blindness			
Cancer			
Diabetes			
Glaucoma			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

Social History

Current Occupation: _____

Education (High School, Vocational School, College Degree): _____

Marital Status (Married, Divorced, Single, Widowed): _____

Living Arrangements: _____

Do you drive? ❒ Yes ❒ No

Do you have visual difficulty when driving? ❒ Yes ❒ No

Do you have problems with night vision? ❒ Yes ❒ No

Have you ever tried to wear contact lenses? ❒ Yes ❒ No

Do you currently wear contact lenses? ❒ Yes ❒ No

If **yes,** how long have you worn contact lenses? _____

Do you currently wear glasses? ❒ Yes ❒ No

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

Do you drink alcohol? ❒ Yes ❒ No

If **yes:**	Occasional	1 per day	2-3 per day	4+ per day

Do you smoke? ❒ Yes ❒ No

If **yes:**	Occasional	½ pack/day	1 pack/day	1+ pack/day

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

History reviewed. ❒ No Changes ❒ Additions, as Noted

_____ _____

Physician's Signature Date