CONNECTICUT
CENTER
for sight

MEDICAL HISTORY QUESTIONAIRE

Name____

Reason for your visit today______________________________Date of last eye exam____________________

EYES – Do you currently have any problems in the following areas?

Blurred vision	Y	N	Eye redness	Y	N
Burning	Y	N	Fluctuating vision	Y	N
Crossed eye/lazy eye	Y	N	Glare/light sensitivity	Y	N
Distorted vision	Y	N	Foreign body sensation	Y	N
Double vision	Y	N	Infection of eye or lid	Y	N
Drooping eyelid	Y	N	Loss of side vision	Y	N
Excessive tearing/watering	Y	N	Loss of vision	Y	N
Eye dryness	Y	N	Mucous discharge	Y	N
Eye itching	Y	N	Sandy or gritty feeling	Y	N
Eye pain or soreness	Y	N	Tired eyes	Y	N

Have you ever been treated for or have any of the following medical conditions?

Arthritis	Y	N	High blood pressure	Y	N
Blindness	Y	N	Kidney disease	Y	N
Cancer	Y	N	Lupus	Y	N
Cataracts	Y	N	Retinal disease	Y	N
Diabetes Type I	Y	N	Stroke	Y	N
Diabetes Type II	Y	N	Thyroid disease	Y	N
Glaucoma	Y	N	Weight loss	Y	N
Heart disease	Y	N	Other______________________________		

If under 14 years old, were you born prematurely? YES NO How many weeks?___________________________

Do you have **ALLERGIES** to medications? Y/N If yes, please list.______________________________________

Have your **parents/siblings/children** had glaucoma, diabetes, high blood pressure, heart disease?

Family member	Medical issue
________________________	____
________________________	____

Do you smoke? YES NO Do you drink alcohol? YES NO

If no, did you ever smoke and if so when did you quit?____

Please list all **MEDICATIONS** you currently take (prescription & over the counter):_________________________

____

List any **EYE surgeries** you have had:____