

PROMONTORY FAMILY VISION MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Reason for today's visit: _____

Who is your primary care doctor? _____ Date of last medical exam? _____

Systemic History

Please explain any yes responses

Cardiovascular: Yes / No
(high blood pressure, heart trouble)

Constitutional: Yes / No
(fever, weight loss)

Ear, nose, throat: Yes / No
(allergies, sinus, chronic cough)

Endocrine: Yes / No
(diabetes, thyroid)

Gastrointestinal: Yes / No
(stomach, intestines, liver)

Genitourinary: Yes / No
(kidney, bladder)

Hematologic: Yes / No
(blood disorders, anemia)

Immunologic: Yes / No
(autoimmune disorders)

Integumentary: Yes / No
(skin)

Musculoskeletal: Yes / No
(muscle pain, joint pain)

Neurological: Yes / No
(headaches, migraines, seizures)

Psychiatric: Yes / No
(depression, bipolar)

Respiratory: Yes / No
(asthma, emphysema)

Other: Yes / No

Personal Ocular Symptoms

Please indicate if you have had any of the following

- Blurry vision _____
- Double vision _____
- Loss of side vision _____
- Dryness _____
- Sensitive to light _____
- Crossed eyes _____
- Itchy eyes _____
- Redness _____
- Ocular discharge _____
- Foreign bodies _____
- Eyelid infections, Bumps _____
- Flashes or Floaters _____
- Other _____

Personal and Family Ocular History

	Yes / No	Self/Family
Cataracts:	Yes / No	Self/Family
Macular degeneration:	Yes / No	Self/Family
Glaucoma:	Yes / No	Self/Family
Retinal detachments:	Yes / No	Self/Family
Diabetes:	Yes / No	Self/Family
Crossed eyes:	Yes / No	Self/Family
Other significant Personal/Family history:		
Have you had any eye surgery?	Yes / No	Which kind?

Pregnant or recent pregnancy? Yes / No

Please list any medications you take (including vitamins and supplements):

Are you Allergic to ANY medications? Yes / No _____

Do you consume alcohol or tobacco? Yes / No, Type/Amount _____ Recreational drugs? Yes/No