

PROMONTORY FAMILY VISION MEDICAL HISTORY QUESTIONNAIRE

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

Reason for today's exam: _____
 Date of last eye exam: _____

Occupation/Hobbies: _____

Do you wear glasses? _____
 Yes/No If yes how old are they? _____

Do you wear contacts? _____
 Yes/No If yes how old are they? _____

Systemic History

Explain 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 & Systemic History

Explain yes responses also mark maternal and paternal

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? Yes / No Amount _____ Do you use recreational drugs? Yes / No

Do you use tobacco? Yes / No Amount _____