Arkansas Eyecare Specialties

Name

MEDICAL HISTORY QUESTIONAIRE

EYE HISTORY

Condition	Yes	No
Headaches	O Yes	O No
Glare/Light Sensitivity	O Yes	O No
Tired Eyes	O Yes	O No
Amblyopia (Lazy Eye)	O Yes	O No
Burning	O Yes	O No
Dryness	O Yes	O No
Excess Tearing/Watering	O Yes	O No
Eye Pain or Soreness	O Yes	O No
Forign Body Sensation	O Yes	O No
Infection of Eye or Lid	O Yes	O No
Itching	O Yes	O No
Mucous Discharge	O Yes	O No
Drooping Eyelid	O Yes	O No
Redness	O Yes	O No
Sandy or Gritty Feeling	O Yes	O No
Strabismus (Crossed Eyes)	O Yes	O No
Blurred Vision Distance	O Yes	O No
Blurred Vision Near	O Yes	O No
Distorted Vision (halos)	O Yes	O No
Double Vision	O Yes	O No
Floaters or Spots	O Yes	O No
Fluctuating Vision	O Yes	O No
Loss of Vision	O Yes	O No
Loss of Side Vision	O Yes	O No

GENERAL HEALTH CONDITION

Condition	Yes	No
Fever	O Yes	O No
Weight Loss	O Yes	O No
Other Systems	O Yes	O No
Ears,Nose,Throat	O Yes	O No
Cardiovascular (high blood pressure etc.)	O Yes	O No
Respiratory (Asthma)	O Yes	O No
Gastrointestinal	O Yes	O No
Kidney	O Yes	O No
Muscles,Bones,Joints	O Yes	O No
Skin	O Yes	O No
Neurological	O Yes	O No
Psychiatric	O Yes	O No
Endocrine	O Yes	O No
Blood/Lymph	O Yes	O No
Allergic	O Yes	O No

Past Illnesses or Injuries: ______________________________ ______________________________

Past Surgeries: ______________________________ ______________________________

Current Medications: ______________________________ ______________________________

______________________________ ______________________________

Medicines that cause reactions or sensitivities: ______________________________

Specific Allergies: ______________________________

FAMILY HISTORY

Condition	Yes	No
Amblyopia (Lazy Eye)	O Yes	O No
Blindness	O Yes	O No
Cataract(s)	O Yes	O No
Color Blindness	O Yes	O No
Glaucoma	O Yes	O No
Mac Degen	O Yes	O No
Retinal Detachment	O Yes	O No
Strabismus (Eye Turn)	O Yes	O No
Arthritis	O Yes	O No
Cancer	O Yes	O No
Diabetes	O Yes	O No
Heart Disease	O Yes	O No
High B.P.	O Yes	O No
Kidney Disease	O Yes	O No
Lupus	O Yes	O No
Stroke	O Yes	O No
Thyroid Disease	O Yes	O No
Other	O Yes	O No