OAKLAND EYE CARE

Medical History Questionnaire

What eye concerns do you have?
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Please answer the following if you have not done so above:
Which Eye?______________________ Problem with vision?______________________
Type of Pain?______________________ How Long?______________________

Does something make your problem better or worse?
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Please circle anything else associated with your problem:

Dryness	Itching	Watering	Redness	Sandy or Gritty Feeling
Aching	Burning	Discharge	Double Vision	Light sensitivity

Past Medical History

LIST ALL CURRENT MEDICATIONS:
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LIST ANY ALLERGIES INCLUDING ALLERGIES TO MEDICATIONS:
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LIST ALL MEDICAL CONDITIONS:
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LIST ANY SURGERIES YOU HAVE HAD INCLUDING THE EYES:
____
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Review of Systems

Have you had or currently have:

Constitutional Symptoms	**YES**	**NO**
Fever	☐	☐
Weight Loss	☐	☐
Allergic/Immunologic		
Seasonal Allergies	☐	☐
Ears, Nose, Mouth, Throat		
Dry throat/Mouth	☐	☐
Cardiovascular (heart/blood vessels)		
High blood pressure	☐	☐
Angina	☐	☐
Previous Heart attacks	☐	☐
Congestive Heart Failure	☐	☐
Respiratory (lungs/breathing)		
Emphysema/COPD/Asthma	☐	☐
Tuberculosis	☐	☐
Gastrointestinal Disease (stomach/intestines)	☐	☐
Genitourinary Disease (genitals/kidneys/bladder)	☐	☐

Musculoskeletal	**YES**	**NO**
Joint Pain	☐	☐
Skin or Breast Disease	☐	☐
Neurological Disease	☐	☐
Psychiatric Disease	☐	☐
Endocrine (hormone system)		
Diabetes	☐	☐
Thyroid Overactive	☐	☐
Thyroid Underactive	☐	☐
Removal or Destruction of Thyroid	☐	☐
Hematologic/Lymphatic		
Cancer	☐	☐
Anemia	☐	☐

If you need to elaborate on one of the above, please do so here:______________________
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Patients Name: ____