Medical Eye Services

48 S. Greenleaf Avenue
Gurnee, IL 60031
847-662-4016

Adult Medical History Questionnaire

Name:_____ Birth Date:_____

Name of physician referring you:_____ Physician Phone:_____

Physician Address:_____ Date of last eye exam:_____

REVIEW OF SYSTEMS
Do you currently have any problems in the following areas? If "yes", provide information.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms			
Fever	☐	☐	_____
Weight loss	☐	☐	_____
Other	☐	☐	
Eyes			
Loss of vision	☐	☐	_____
Blurred vision	☐	☐	_____
Distorted vision (halos)	☐	☐	_____
Loss of side vision	☐	☐	_____
Double vision	☐	☐	_____
Dryness	☐	☐	_____
Mucous discharge	☐	☐	_____
Redness	☐	☐	_____
Sandy or gritty feeling	☐	☐	_____
Itching	☐	☐	_____
Burning	☐	☐	_____
Foreign body sensation	☐	☐	_____
Excess tearing/watering	☐	☐	_____
Occasional tearing	☐	☐	_____
Glare/Light sensitivity	☐	☐	_____
Eye pain or soreness	☐	☐	_____
Chronic infection of eye or lid	☐	☐	_____
Sties, Chalazion	☐	☐	_____
Fluctuating visual acuity	☐	☐	_____
Tired eyes	☐	☐	
Ears, nose, mouth, throat			
Sinus congestion	☐	☐	_____
Runny nose	☐	☐	_____
Post-nasal drip	☐	☐	_____
Chronic cough	☐	☐	_____
Dry throat/mouth	☐	☐	_____
Respiratory (lungs/breathing)	☐	☐	_____
Chronic bronchitis	☐	☐	_____

Cardiovascular (heart/blood vessels)	☐	☐	_____
Gastrointestinal (stomach/intestines)	☐	☐	_____
Genitourinary (genitals/kidney/bladder)	☐	☐	_____
Musculoskeletal			
Joint pain	☐	☐	_____
Integumentary (skin and/or breast)	☐	☐	_____
Neurological	☐	☐	_____
Psychiatric	☐	☐	_____
Endocrine	☐	☐	
Hematologic/Lymphatic			
Blood	☐	☐	_____
Lymph nodes	☐	☐	_____
Swelling	☐	☐	_____
Allergic/Immunologic	☐	☐	_____
Head allergy symptoms	☐	☐	_____
Psychiatric	☐	☐	_____

PAST HISTORY

List any medications you take:

_____

_____

List all major illnesses and injuries::

_____

_____

List any surgeries you have had::

_____

_____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes?:

_____

_____

	YES	NO
Do you have allergies to any medications?	☐	☐

If YES, list medications:

_____

_____

FAMILY HISTORY

DISEASE	YES	NO	EXPLANATION OF PROBLEM
Blindness	☐	☐	_____
Cataract	☐	☐	

FAMILY HISTORY-Continued

Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer .	☐	☐	_____
Diabetes	☐	☐	_____
Heart attacks	☐	☐	_____
High blood pressure	☐	☐	_____
Kidneydisease	☐	☐	_____
Lupus	☐	☐	_____
Sjogrens Syndrome	☐	☐	_____
Stroke	☐	☐	_____
Thyroid disease	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Current occupation:

_____

Do you drive?	☐	☐
Do you have visual difficulty when driving?	☐	☐
Do you have problems with night vision?	☐	☐
Have you ever tried to wear contacts?	☐	☐
Do you currently wear glasses?	☐	☐
If YES, how long have you had the current pair?	☐	☐
Do you drink alcohol?	☐	☐
If YES, how many glasses a day	_____	
Do you smoke?	☐	☐
if YES, how many packs a day	_____	
Have you ever had a blood transfusion?	☐	☐
Have you ever been in intimate contact with a person who had a sexually transmitted disease?	☐	☐

Patient Signature: _____ Date:_____

History Reviewed: ☐ No changes ☐ Additions as noted above

Physician Signature: _____ Date:_____