

Eye Care Center of Napa Valley Medical History Questionnaire

Name _____	Date _____
Date of Birth _____	Date of last eye exam _____
List any medications you currently take (prescription and over the counter): _____	
Do you have allergies to any medications: YES NO	
If YES, list the medications: _____	
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): _____	
List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____	
Who is your primary care doctor? _____	

Do you currently have any problems in the following areas? If YES, please provide information.

	YES	NO	Details
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			

Please turn over for other side →

RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Do you drive?..... **YES NO**

Do you have visual difficulty when driving?..... **YES NO**

Do you have problems with night vision?..... **YES NO**

Have you ever tried to wear contact lenses?..... **YES NO**

Do you currently wear contact lenses?..... **YES NO** If YES, how long? _____

Do you currently wear glasses?..... **YES NO** If YES, how long have you had your current prescription? _____

Have you ever had a blood transfusion?..... **YES NO**

Do you drink alcohol?.... **YES NO** If YES: occasional 1/day 2-3 /day 4+ /day

Do you smoke?..... **YES NO** If YES: occasional ½ pack /day 1 pack / day 1+ pack /day

*Richard A. Beller, M.D. Alishia Chan, O.D. Michelle F. Kerr, O.D.
Paul K. Row, M.D. Joelle M. Zarzana, O.D.*