

**Eye Physicians of Central Florida**  
**A Division of Florida Pediatric Associates, LLP**

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**Medical History Questionnaire**

**Date:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If Minor, Parents' Names: \_\_\_\_\_

Reason For Visit: \_\_\_\_\_

List any medications you currently take (prescription and over the counter):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies or reactions to medications? No Yes (explain)

\_\_\_\_\_

Please list all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, eye injuries, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Birth History**

(if patient is a minor) \_\_\_\_\_ Birth weight: \_\_\_\_\_ number of siblings: brother(s) \_\_\_\_\_  
gestation (wks): \_\_\_\_\_ sister(s) \_\_\_\_\_  
delivery: normal Caesarian

**Do you currently have any problems in the following areas:**

Explanation or comments

**Eye conditions or injuries**

Loss of vision	Yes	No
Blurred vision	Yes	No
Distorted vision	Yes	No
Loss of side vision	Yes	No
Double vision	Yes	No
Dryness	Yes	No
Mucous discharge	Yes	No
Redness	Yes	No
Sandy or gritty feeling	Yes	No
Itching	Yes	No
Burning	Yes	No
Foreign body sensation	Yes	No
Excess tearing/watering	Yes	No
Glare/light sensitivity	Yes	No
Eye pain or soreness	Yes	No
Infection of eye or eyelid	Yes	No
Tired eyes	Yes	No
Crossed eyes, lazy eye	Yes	No
Drooping eyelid	Yes	No

Explanation or comments

**General/Constitutional conditions**

Fever	Yes	No
Weight Loss	Yes	No
Other	Yes	No
Ears, Nose, Throat (Sinus, ear infection, cough, dry mouth, etc.)	Yes	No
Cardiovascular (heart, vessels, etc.)	Yes	No
Respiratory (Asthma, emphysema, etc.)	Yes	No
Gastrointestinal (stomach ulcers, bowel disease, etc.)	Yes	No
Genital, Kidney, Bladder	Yes	No
Muscles, Bones, Joints (arthritis, etc.)	Yes	No
Skin (acne, warts, skin cancer, etc.)	Yes	No
Neurological (multiple sclerosis, etc.)	Yes	No
Psychiatric (anxiety, depression, insomnia, etc.)	Yes	No
Endocrine (diabetes, thyroid, etc.)	Yes	No
Blood/Lymph (Cholesterol, Anemia, etc.)	Yes	No
Allergic/Immunologic (hay fever, lupus, etc.)	Yes	No

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

Condition	Relationship to patient			
	Yes	No	M	F S GP
Blindness	Yes	No	M	F S GP
Amblyopia (lazy eye)	Yes	No	M	F S GP
Strabismus (eye turning in or out)	Yes	No	M	F S GP
Glaucoma	Yes	No	M	F S GP
Arthritis	Yes	No	M	F S GP
Cancer	Yes	No	M	F S GP
Diabetes	Yes	No	M	F S GP
Heart disease or high blood pressure	Yes	No	M	F S GP
Kidney disease	Yes	No	M	F S GP
Lupus	Yes	No	M	F S GP
Stroke	Yes	No	M	F S GP
Thyroid disease	Yes	No	M	F S GP
Other	Yes	No	M	F S GP

**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 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	How long?
Do you currently wear glasses?	Yes	No	How old are these glasses?
Do you drink alcohol?	Yes	No	How many drinks per day?
Do you smoke?	Yes	No	How many packs per day?
Have you ever had a blood transfusion?	Yes	No	

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

History reviewed:   
 Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_