Print Form

MALONEY VISION INSTITUTE®

Medical Eye Examination
Patient History Questionnaire

Name:_____ Date: _____
(Last) (First) (MI)

Date of Birth: _____ Occupation: _____ Employer: _____

If an eye doctor suggested you see us, please provide the doctor's name: _____

What bothers you most about your current vision and how it impacts your quality of life?

_____

_____

_____

_____

List activities and hobbies that you enjoy: _____

_____

_____

What do you currently wear? – (*check any that apply* - ☐ glasses, ☐ soft contacts, ☐ hard contacts, ☐ rigid gas-permeable contacts, ☐ scleral lenses). What are you biggest problems with these?

_____

_____

_____

_____

Have you had any other second opinions about your vision? ☐ Yes ☐ No

If yes, with who? _____

_____

What questions do you have that we could address during your consultation?

_____

_____

_____

_____

Medical and Eye History

List all **eye injuries or diseases** you have had (glaucoma, cataract, etc.):

_____

_____

_____

List all **eye surgeries** you have had:

	Type of Surgery	Which Eye	Surgeon's Name	Date
1)				
2)				
3)				
4)				

List all **eye drops** you use, which eye, and how often you use them:

_____

_____

_____

List any oral or injected **medications** you currently take (Rx and over-the-counter):

_____

_____

_____

List any medications you are **allergic** to:

_____

_____

_____

List all **medical problems** you have:

_____

_____

_____

If female, are you or might you be pregnant? ☐ Yes ☐ No

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

	YES	NO	Details
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (growths, rashes, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)?

Blindness, Keratoconus, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Do you drink alcohol? .....**YES** ☐ **NO** ☐ If YES, how much? _____

Do you smoke?.....**YES** ☐ **NO** ☐ If YES, how much? _____ How many years? _____

Physician's Signature _____ Date_____