Timothy P. Walker, O.D.

MEDICAL HISTORY QUESTIONNAIRE

Name_____ Today's Date:_____/_____/_____

Last Eye Exam:_____/_____/_____ Last Medical Exam:_____/_____/_____

Medical History

Do you have any allergies to medications? Yes or No If yes, please explain:_____

_____

List any medications you take (or you can provide a list of medications at your visit) :

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations: _____

_____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, keratoconus, eye infections or eye injury.

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses?_____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable?_____

(If you have your contact lens information, please bring it with you, i.e. prescription or boxes.)

Ocular History- Have you or any of your relatives, living or deceased, had any of these conditions?

Blindness	Yes	No	Unsure	Relation: _____
Cataract	Yes	No	Unsure	_____
Crossed Eyes	Yes	No	Unsure	_____
Glaucoma	Yes	No	Unsure	_____
Macular Degeneration	Yes	No	Unsure	_____
Retinal Detachment/Disease	Yes	No	Unsure	_____

Review of Systems

Do you currently, or have you ever had chronic problems in the following area:

System

Constitutional

Fever, Weight Loss/Gain	No	Yes	Unsure

Neurological

Headaches	No	Yes	Unsure
Migraines	No	Yes	Unsure
Seizures	No	Yes	Unsure

Eyes

Loss of Vision	No	Yes	Unsure
Blurred Vision	No	Yes	Unsure
Distorted Vision/Halos	No	Yes	Unsure
Loss of Side Vision	No	Yes	Unsure
Dryness	No	Yes	Unsure
Sandy or Gritty Feeling	No	Yes	Unsure
Itching	No	Yes	Unsure
Burning	No	Yes	Unsure
Excess Tearing/Watering	No	Yes	Unsure
Chronic Infection of Eye or Lid	No	Yes	Unsure
Sties or Chalazion	No	Yes	Unsure
Flashes/Floaters in Vision	No	Yes	Unsure

Endocrine

Thyroid/Other Glands	No	Yes	Unsure

Ear, Nose, Mouth, Throat

Allergies/Hay Fever	No	Yes	Unsure
Sinus Congestion	No	Yes	Unsure
Dry Throat/Mouth	No	Yes	Unsure

Respiratory

Asthma	No	Yes	Unsure
Chronic Bronchitis	No	Yes	Unsure
Emphysema	No	Yes	Unsure

Vascular/Cardiovascular

Diabetes	No	Yes	Unsure
Elevated Cholesterol	No	Yes	Unsure
Heart Pain	No	Yes	Unsure
High Blood Pressure	No	Yes	Unsure
Vascular Disease	No	Yes	Unsure

Bones/Joints/Muscles

Rheumatoid Arthritis	No	Yes	Unsure
Muscle Pain	No	Yes	Unsure
Joint Pain	No	Yes	Unsure

Lymphatic/Hematologic

Anemia	No	Yes	Unsure
Bleeding Problems	No	Yes	Unsure

Allergic/Immunologic	No	Yes	Unsure
Psychiatric	No	Yes	Unsure

Other Health Issues not listed:_____

_____

_____

_____

_____

***Please bring all forms with you to your appointment!**

We look forward to seeing you!