Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Home Phone: _____

_____ Work Phone:_____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Cell Phone: _____

Employer / School_____Occupation:_____

How did you choose this office?

___ Referred by Patient ____Referred by Doctor ____Phone Book ____Insurance Co. ____Location _____Other

Who may we thank for referring you to this office? Name: _____

Name of Medical Doctor: _____ Last Eye Exam _____ / _____ / _____

Last Medical Exam _____ / _____ / _____

Medical History

Do you have any allergies or allergies to medications?: ❑ no ❑ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

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

_____

Please check if you have ever had any of the following: ☐Cataracts / ☐Glaucoma / ☐Lazy Eye / ☐Crossed Eyes / ☐Drooping Eyelid / ☐ Prominent Eyes / ☐Macular Degeneration / ☐Retinal Disease / ☐Eye Injury / ☐Eye Surgery / ☐Eye Infections

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? ❑ yes ❑ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eyes/Lazy Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other_____	❑	❑	❑	_____

** Please turn this form over and complete side two **

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes If yes, please describe:

_____

Do you use tobacco products? ❑ no ❑ yes If yes, type / amount / how long: _____

Do you drink alcohol? ❑ no ❑ yes If yes, type / amount / how long: _____

Do you use illegal drugs? ❑ no ❑ yes If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑ No

Review of Systems

Do you currently have any problems in the following areas:

System	No	Yes	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
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	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Styes or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

System	No	Yes	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CADIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____ _____

Signature Date

_____ _____

Doctor's Signature Date