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 ☐ Insuarance 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 circle 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	☐	☐	☐

	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