

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	?	No	Yes	?
CONSTITUTIONAL						
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
NEUROLOGICAL						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EYES						
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ENDOCRINE						
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EARS, NOSE, MOUTH, THROAT						
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
RESPIRATORY						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
VASCULAR / CADIOVASCULAR						
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GASTROINTESTINAL						
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY						
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
BONES / JOINTS / MUSCLES						
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
LYMPHATIC / HEMATOLOGIC						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
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