MEDICAL HISTORY QUESTIONNAIRE

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

Address: _____ Social Security #: _____

_____ Phone: (_____) _____-_____

Birth Date: ____/____/____ Age: _____ Sex: □M □F Last Eye Exam: _____/_____/_____

E-Mail Address: _____

Employer/School: _____ Occupation/Grade: _____

Employer/School Phone: (____) _____-_____ Hobbies: _____

How did you hear of our office? _____ _____

If someone referred you, please indicate name: _____

May we use your name in thanking this person? □No □Yes

Medical History

Name of Medical Doctor: _____ Dr.'s Phone: (_____) _____-_____

Last Medical Exam: _____/_____/_____

Do you have any 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: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, 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 current pair? _____

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

If no, are you interested? _____

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other

Are they comfortable? □ No □ Yes

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	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____

**** PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO ****

Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

☐ 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

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

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

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

_____

_____

_____

_____ _____

Doctor's Signature Date