

Medical History Questionnaire

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

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____ Cell # _____

Date of Birth: ____/____/____ Social Security # ____/____/____

Last Eye Exam: ____/____/____ Last Medical Exam: ____/____/____

Name of Medical Doctor: _____

Name of Employer: _____

How were you referred to our office: _____ Please list parents name if minor: _____
(If referred by friend or family please list name)

Medical History

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 eyes, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injuries: _____

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 contacts? no yes If yes, how old is your present pair of lenses? _____

Type of contacts 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
1. Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. 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

Review of Systems

Do you currently, or have you ever had 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"/>			
Sties 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 / CARDIOVASCULAR						
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:

Doctor's Signature

Date