

Medical History Questionnaire

Name: _____

Today's Date: _____

Address: _____

Home #: _____

City, State, Zip _____

Cell #: _____

Guardian (If Applicable) _____

Occupation _____

Date of birth ___/___/___ SS # ___/___/___

Work #: _____

Last Eye Exam _____

School Grade (children) _____

Name of Primary Care Doctor: _____

Medical Insurance _____

Last Medical Exam _____

Vision Insurance _____

Referred by _____

Spouse and children's names _____

Medical History

Do you have any allergies to medications? No Yes If yes, explain _____

List any medications you take (including over the counter) _____

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

Are you pregnant and/ or nursing? Yes No

Have you had any of the following?

Crossed Eyes Lazy Eye Drooping Eyelid Prominent Eyes Glaucoma Retinal Disease Cataracts

Eye Infections Eye Injury None

Do you wear glasses? Yes No If yes, how old is your present pair of lenses? _____

Do you wear contacts? Yes No If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft/ Extended Wear Other/ Are they comfortable? _____

Family History

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

Disease/Condition

Relationship to you

Blindness	Yes	No	Unsure	_____
-----------	-----	----	--------	-------

Cataract	Yes	No	Unsure	_____
----------	-----	----	--------	-------

Crossed Eye	Yes	No	Unsure	_____
-------------	-----	----	--------	-------

Glaucoma	Yes	No	Unsure	_____
----------	-----	----	--------	-------

Macular Degeneration	Yes	No	Unsure	_____
----------------------	-----	----	--------	-------

Retinal Detachment/ Disease	Yes	No	Unsure	_____
-----------------------------	-----	----	--------	-------

Arthritis	Yes	No	Unsure	_____
-----------	-----	----	--------	-------

Cancer	Yes	No	Unsure	_____
--------	-----	----	--------	-------

Diabetes	Yes	No	Unsure	_____
----------	-----	----	--------	-------

Heart Disease	Yes	No	Unsure	_____
---------------	-----	----	--------	-------

High Blood Pressure	Yes	No	Unsure	_____
---------------------	-----	----	--------	-------

Kidney Disease	Yes	No	Unsure	_____
----------------	-----	----	--------	-------

Lupus	Yes	No	Unsure	_____
-------	-----	----	--------	-------

Thyroid Disease	Yes	No	Unsure	_____
-----------------	-----	----	--------	-------

Other _____				_____
-------------	--	--	--	-------

Social History This information is kept strictly confidential. However, you may speak directly to the doctor if you prefer.

Do you have visual difficulty when driving? Yes No If yes, please describe _____

Do you use tobacco products? Yes No If yes, type/amount/how long? _____

Do you drink alcohol? Yes No If yes, type/amount/how long? _____

Do you use illegal drugs? Yes No If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

Review of Systems

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

	Yes	No		Yes	No
Constitutional			Ears, Nose, Mouth, Throat		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			Respiratory		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/ Cardiovascular		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy to Gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/ Hematologic		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>			

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

Doctor's Signature

Date