Medical **H**istory **Q**uestionnaire

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	□	□	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 to 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 or Lid	□	□	Muscle Pain	□	□
Sties or Chalazion	□	□	Joint Pain	□	□
Flashes/Floaters in Vision	□	□	**Lymphatic/ Hematologic**		
Tired Eyes	□	□	Anemia	□	□
Endocrine			Bleeding	□	□
Thyroid/Other Glands	□	□	**Allergic/Immunologic**	□	□
Psychiatric	□	□			

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

_____

_____

_____

_____ _____

Doctor's Signature Date