

# Tri-City Optometry Medical History Questionnaire

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone # \_\_\_\_\_

Guardian (If Applicable): \_\_\_\_\_

## **Medical History**

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

\_\_\_\_\_

List any medication/s you take (including oral contraceptives, aspirin, & over the counter medications):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

List any of the following that you have had: crossed eye, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, 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? \_\_\_\_\_

Do you wear contacts? ☐ no ☐ yes If yes, how old is your present pair? \_\_\_\_\_

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ yes ☐ no

## **Family History**

### **Relationship to you**

Blindness ☐ no ☐ yes \_\_\_\_\_

Cataracts ☐ no ☐ yes \_\_\_\_\_

Crossed Eyes ☐ no ☐ yes \_\_\_\_\_

Glaucoma ☐ no ☐ yes \_\_\_\_\_

Macular Degeneration ☐ no ☐ yes \_\_\_\_\_

Retinal Disease ☐ no ☐ yes \_\_\_\_\_

Diabetes ☐ no ☐ yes \_\_\_\_\_

Arthritis ☐ no ☐ yes \_\_\_\_\_

Cancer ☐ no ☐ yes \_\_\_\_\_

Heart Disease ☐ no ☐ yes \_\_\_\_\_

High Blood Pressure ☐ no ☐ yes \_\_\_\_\_

Kidney Disease ☐ no ☐ yes \_\_\_\_\_

Lupus ☐ no ☐ yes \_\_\_\_\_

Thyroid Disease ☐ no ☐ yes \_\_\_\_\_

Other ☐ no ☐ yes \_\_\_\_\_

**\*Please fill out backside\***

## Social History

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: \_\_\_\_\_

Do you drink alcohol? ☐no ☐yes If yes, type /amount: \_\_\_\_\_

Do you use illegal drugs? ☐no ☐yes If yes, what type: \_\_\_\_\_

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	YES	NO		YES	NO
<b>Constitutional</b>			<b>Ears, Nose Mouth , Throat</b>		
Fever, Weight Loss/ Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>			Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			<b>Respiratory</b>		
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/ Halos	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/ Cardiovascular</b>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritting Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/ Muscles</b>		
Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/ Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/ Hematologic</b>		
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sties	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any above or has a condition not listed, please explain:

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Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_