Medical History Questionnaire

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

Birth Date: _____/_____/_____ Date of last eye exam: _____

Name of Medical Doctor: _____ Doctor's Phone # _____
Date of last medical exam: _____

Medical History:

Do you have any allergies to medication? ☐ Yes ☐ No If yes, which ones: _____
_____

Current medications you take: (Include prescription meds, insulin, over-the-counter and vitamins):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List any **EYE** related disease, injuries or surgeries: _____
_____

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

Check any of the following that you have had: ☐ Crossed eyes ☐ Lazy eye ☐ Glaucoma ☐ Cataracts ☐ Eye Injury ☐ Drooping eyelid ☐ Retinal Disease ☐ Prominent eyes ☐ Eye infections

Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

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

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

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear Are they comfortable? ☐ Yes ☐ No

Family History:

Note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	Yes	No	?	Relationship To You
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment	☐	☐	☐	
Arthritis	☐	☐	☐	

Disease/Condition	Yes	No	?	Relationship To You
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
Hypertension	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Other:				

*** Please Turn This Form Over & Complete Side Two ***

Social History: *This information is kept strictly condfidential. 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 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

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Review of Systems: Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

INTEGUMENTARY (SKIN)	Y	N
Eczema	☐	☐
Psoriasis	☐	☐
Rosacea	☐	☐

NEUROLOGICAL	Y	N
Alzheimer's Disease	☐	☐
Autism	☐	☐
Bell's Palsy	☐	☐
Cerebral Palsy	☐	☐
Epilepsy	☐	☐
Headaches/Migraines	☐	☐
Multiple Sclerosis	☐	☐
Parkinson's Disease	☐	☐
Seizure Disorder	☐	☐

ENDOCRINE	Y	N
Diabetes	☐	☐
Graves Disease	☐	☐
Thyroid Disorder	☐	☐

RESPIRATORY	Y	N
Allergies	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐

CANCER	Y	N
_____	☐	☐

CARDIOVASCULAR	Y	N
Angina Pectoris/Chest Pain	☐	☐
Artificial Heart Valve	☐	☐
Congestive Heart Failure	☐	☐
Elevated Cholesterol	☐	☐
Heart Attack	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Pacemaker	☐	☐
TIA/Stroke	☐	☐

GASTROINTESTINAL	Y	N
Cirrhosis	☐	☐
Diverticulosis	☐	☐
Irritable Bowel Syndrome	☐	☐

GENITOURINARY	Y	N
Kidney Disease	☐	☐

MUSCULOSKELETAL	Y	N
Arthritis	☐	☐
Joint Pain	☐	☐
Muscle Pain	☐	☐
Osteoporosis	☐	☐
Rheumatoid Arthritis	☐	☐

LYMPHATIC/HEMATOLOGIC	Y	N
Anemia	☐	☐
Leukemia	☐	☐
Shingles	☐	☐
Sjogren's Syndrome	☐	☐

PSYCHIATRIC	Y	N
ADHD	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
Dementia	☐	☐
Depression	☐	☐
Schizophrenia	☐	☐

EYES	Y	N
Blurred Vision	☐	☐
Burning	☐	☐
Distorted Vision/Halos	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Excess Tearing/Watering	☐	☐
Eye Pain or Soreness	☐	☐
Flashes/Floaters	☐	☐
Foreign Body Sensation	☐	☐
Fuchs Dystrophy	☐	☐
Glare/Light Sensitivity	☐	☐
Itching	☐	☐
Loss of Side Vision	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Sties or Chalazion	☐	☐
Tired Eyes	☐	☐

OTHER NOT LISTED

_____

_____

_____

Doctor's Signature: _____ Date:_____