Northeast Eye Center
Michelle L. Martinez O.D. P.A.

Medical History Questionnaire

Patient Name: _____ Date _____

Date of Last Eye Exam _____Date of Last Medical Exam _____

Do you drive? ☐Yes Do you have visual difficulty while driving? ☐Yes

If yes, please describe _____

Do you wear glasses? ☐Yes Do you wear contacts? ☐Yes

Type of contacts: ☐Soft ☐Gas Permeable ☐Extended Wear ☐Toric ☐Multifocal ☐Daily Wear ☐Other

Have you ever had any of the following?

Eye Surgery ☐ Yes Eye Injuries ☐ Yes Light Flashes ☐ Yes Dry Eyes ☐ Yes
Severe Eye Pain ☐ Yes Double Vision ☐ Yes Lazy Eye ☐ Yes
If yes, explain _____

Tobacco Use

Never Smoked ☐ Former Smoker ☐ Current Daily Smoker ☐ Current Social Smoker ☐

Smokeless Tobacco ☐ Number of daily Cigarettes ☐ 1- 9 daily ☐ 10 or more daily

Alcohol Use

None ☐ Social Drinker ☐ 1-2 Drinks Daily ☐ Alcohol Dependence ☐

illegal Drug Use

None ☐ Recreational Use ☐ Dependence ☐

Family History

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

Disease/Condition	Yes	?	Relationship	Maternal/Paternal	
Blindness	☐	☐	_____	☐	☐
Cataract	☐	☐	_____	☐	☐
Crossed Eyes	☐	☐	_____	☐	☐
Glaucoma	☐	☐	_____	☐	☐
Macular Degeneration	☐	☐	_____	☐	☐
Retinal Detachment/Disease	☐	☐	_____	☐	☐
Arthritis: (type) _____	☐	☐	_____	☐	☐
Cancer:(type) _____	☐	☐	_____	☐	☐
Diabetes:(type) _____	☐	☐	_____	☐	☐
Heart Disease	☐	☐	_____	☐	☐
High Blood Pressure	☐	☐	_____	☐	☐
Kidney Disease	☐	☐	_____	☐	☐
Lupus	☐	☐	_____	☐	☐
Thyroid Disease	☐	☐	_____	☐	☐
Cholesterol	☐	☐	_____	☐	☐
Other: _____	☐	☐	_____	☐	☐

Medical History

This information is kept strictly confidential. However, you may discuss this with the doctor if you prefer.

Are you pregnant or nursing? ☐Yes

Have you ever had a blood transfusion? ☐Yes If yes, explain: _____

Any Sexually Transmitted Disease? ☐Yes If yes, explain: _____

Are you under a physician's care? ☐Yes If yes, explain: _____

Do you have any allergies to medications? ☐Yes If yes, explain: _____

List medications taken (including oral contraceptives, aspirin, over the counter medication and home remedies):

_____

_____

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

_____

Please turn page over and complete both sides

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Medical History Continued

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

Constitutional	**Yes**	**?**
Fever, Weight loss/Gain	☐	☐
Integumentary (skin)	☐	☐
Neurological		
Headaches	☐	☐
Headaches at Night	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing, Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/Other glands	☐	☐
Allergic/Immunologic	☐	☐

Ear, Nose, Mouth, Throat	**Yes**	**?**
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory	☐	☐
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema		
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Elevated Cholesterol	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary	☐	☐
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Osteo Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Blood Thinners	☐	☐
Psychiatric	☐	☐

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

_____

_____

Please turn page over and complete both sides