Medical History Questionnaire

Today's Date:_____

Name:_____ **Phone:** _____ **Email:** _____

Address: _____ **Work:** _____ **Occupation:**_____

_____ **Cell:** _____ **Company:** _____

Birth Date: _____/ _____/ _____ **Social Security:**_____

Person Responsible For Bill / DOB: _____ **Last Eye Exam:** _____ /_____ /_____

Name of Medical Doctor: _____ **Dr's Phone:** _____

Referred by: _____ **Last Medical Exam:** ___ / ___ / _____

Are you pregnant and/or nursing? YES _____ **NO** _____

Allergies to Medications? YES____ **NO** _____ **If Yes, Explain:** _____

List any medications you take: (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

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

_____

Do you wear glasses? YES_____ **NO** _____ **If yes, how old is your current pair of lenses?**_____

Do you wear contact lenses? YES_____ **NO** _____ **If yes, hold old is your current pair?** _____

Type of Contact Lenses: Soft _____ **Rigid** _____ **Extended Wear** _____ **Other** _____ **Are they comfortable? YES**_____ **NO** _____

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas?

EYES:

Loss of Vision	YES / NO
Blurred Vision	YES / NO
Distorted Vision/Halos	YES / NO
Loss of Side Vision	YES / NO
Double Vision	YES / NO
Dryness	YES / NO
Mucous Discharge	YES / NO
Redness	YES / NO
Sandy or Gritty Feeling	YES / NO
Itching	YES / NO
Burning	YES / NO
Foreign Body Sensation	YES / NO
Excess Tearing/Watering	YES / NO
Glare/Light Sensitivity	YES / NO
Eye Pain or Soreness	YES / NO
Chronic Infection of Eye/ Lid	YES / NO
Sties or Chalazion	YES / NO
Flashes/Floaters in Vision	YES / NO
Tired Eyes	YES / NO

CONSTITUTIONAL:

Fever, Weight Loss/ Gain	YES / NO

CARDIOVASCULAR:

Heart Pain	YES / NO
High Blood Pressure	YES / NO
Vascular Disease	YES / NO
Pacemaker	YES / NO
Stroke	YES / NO
High Cholesterol	YES / NO
Other _____	

EARS/NOSE/MOUTH/THROAT:

Allergies/Hay Fever	YES / NO
Sinus Congestion	YES / NO
Runny Nose	YES / NO
Post-Nasal Drip	YES / NO
Chronic Cough	YES / NO
Dry throat/mouth	YES / NO
Other _____	

RESPIRATORY:

Asthma	YES / NO
Chronic Bronchitis	YES / NO
Emphysema	YES / NO
C.O.P.D.	YES / NO
Other _____	

GASTROINTESTIONAL:

Diarrhea	YES / NO
Constipation	YES / NO
Gastric Reflux	YES / NO
Other _____	

GENITOURINARY:

Genitals/Kidney/Bladder	YES / NO
Other _____	

MUSCULOSKELETAL:

Arthritis	YES / NO
Rheumatoid Arthritis	YES / NO
Other _____	

REVIEW OF SYSTEMS CONTINUED:

INTEGUMENTARY:

Skin Irritation/Disorder YES / NO
Skin Cancer YES / NO
Other _____

NEUROLOGICAL:

Headaches YES / NO
Migraines YES / NO
Seizures YES / NO
Other _____

PSYCHIATRIC:

Depression YES / NO
Anxiety YES / NO
Other _____

HEMATOLOGIC/ LYMPHATIC:

Anemia YES / NO
Bleeding Problems YES / NO
Other _____

Endocrine:

Diabetes Type 1 YES / NO
Diabetes Type 2 YES / NO
BS/HgbA1c_____ Date_____
Thyroid/Other Glands YES / NO
Other _____

ALLERGIC/ IMMUNOLOGIC: YES / NO

PERSONAL EYE HISTORY:

Glaucoma YES / NO
Retinal Disease YES / NO
Macular Degeneration YES / NO
Diabetic Retinopothy YES / NO
Eye Infections YES / NO

Crossed eye YES / NO
Lazy eye YES / NO
Drooping eyelid YES / NO
Prominent eyes YES / NO
Eye Injury YES / NO

Cataracts YES / NO
If Yes: Which eye? R / L / B
Surgery Year: R _____
L _____

SOCIAL HISTORY:

Do you drive? YES / NO If Yes, do you have visual difficulty when driving? YES / NO If Yes, please describe: _____

_____

Do you drink alcohol? YES / NO If Yes, type/amount/how long?_____

Do you use tobacco products? YES / NO Do you smoke? YES / NO If Yes, how much/how long? _____

Do you use illegal drugs? YES / NO If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: (if yes, circle) Gonorrhea Hepatitis HIV Syphilis None

FAMILY HISTORY:

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

DISEASE/CONDITION	YES/NO	RELATIONSHIP TO YOU
Blindness	YES / NO	_____
Cataract	YES / NO	_____
Crossed Eye	YES / NO	_____
Glaucoma	YES / NO	_____
Macular Degeneration	YES / NO	_____
Retinal Detachment/Disease	YES / NO	_____
Arthritis	YES / NO	_____
Cancer	YES / NO	_____
Diabetes	YES / NO	_____
Heart Disease	YES / NO	_____
High Blood Pressure	YES / NO	_____
Lupus	YES / NO	_____
Thyroid Disease	YES / NO	_____
High Cholesterol	YES / NO	_____

Other_____