Medical History Questionnaire

Please fill out in blue or black ink only.

Today's Date:_____/_____/_____
Patient Name:_____Date of Birth_____/_____/_____
Patient phone #:_____
Name of Medical Doctor_____Date of last Exam_____/_____/_____
Doctor's phone:_____Fax number:_____
Name of Last Eye Doctor_____Date of last Exam:_____/_____/_____
Eye Doctor's phone:_____Fax number:_____
Guardian's name (if applicable):_____Guardian's phone:_____

MEDICAL HISTORY

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

_____

_____

List any medications you take (including pills, creams, drops, contraceptives, aspirin, over-the counter medications, and home remedies): _____

_____

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

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury:_____

Are you pregnant and/or nursing? ☐ No ☐ Yes If yes, when is your due date?_____
Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____
Type of contacts: ☐ Rigid ☐ Soft ☐ Extended Wear (sleep in) ☐ Other:_____Are they comfortable ☐ No ☐ Yes
Wearing schedule: ☐ Daily ☐ 2 week ☐ monthly Current brand and prescription_____

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other:_____	☐	☐	☐	_____

****PLEASE COMPLETE THE SECOND PAGE OF THIS FORM****

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

I would prefer to discuss my Social History information directly with the doctor. (Check Box) ☐

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/how long?_____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long?_____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long?_____

Have you ever been exposed to or infected with(check all that apply, if any): ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever	☐	☐	☐
Recent Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY(SKIN)			
Rash/Itching/New Growth	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Dizziness/Lightheadedness	☐	☐	☐
Seizures	☐	☐	☐
Numbness/Tingling Sensation	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Distance Vision	☐	☐	☐
Blurred Near Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Night Vision Problems	☐	☐	☐
Color Vision Problems	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid Problems	☐	☐	☐
Other Gland Problems	☐	☐	☐

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
COPD	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart/Chest Pains	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/HEMATOLOGIC			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain/Weakness	☐	☐	☐
Joint Pain/Weakness	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding/Bruising Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC			
Eczema	☐	☐	☐
Immunological Disease	☐	☐	☐
PSYCHIATRIC			
Memory Loss/Confusion	☐	☐	☐
Nervousness/Panic Attacks	☐	☐	☐

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

_____

_____

_____

_____ _____

Doctor's Signature Date