STUDIOOPTICS

BOSTON
229 Berkeley St
Boston, MA 02116
(617) 247-0012
info@studiooptics.net

FRAMINGHAM
659 Worcester Rd,
Framingham, MA 01701
(508) 872-2722
studio.optics1@verizon.net

Medical History Questionnaire

Legal Name First Middle Initial Last

Preferred Name	Date of Birth	Gender ☐Male ☐Female ☐Non-Binary ☐Other:_____
Pronouns	Employer/Occupation	
Cell Phone	Home Phone	Work Phone / Best number to call ☐Cell ☐Home ☐Work
Email Address		Preferred contact method ☐Text Message ☐Email ☐Call
Address	City	State Zip

Insurance Information

Vision Insurance		Vision Member ID #	
Medical Insurance	Plan Phone # (from ID Card)	Medical Insurance ID #	Policy #/Group #
Primary Member Name (if not self)		Date of Birth	Relationship to Primary ☐Spouse ☐Child ☐Other:_____

Ocular History

Last eye exam	Doctor's Name	Office Phone #

What is your reason for seeking vision care today?

Are you interested in?	Do you currently wear?	Types of CLs worn	Are they comfortable?
☐Clear/colored contact lenses	☐Glasses	☐Disposable	☐No
☐Laser vision surgery	☐Contact lenses (CLs)	☐Rigid	☐Yes
☐Bifocals without lines		☐Soft	

Contact Lens Brand
Left Right

CLs Prescription (BC, DIA, Power/Sphere, CYL, Axis)
Left Right

Medical History

Last medical exam	Doctor's Name	Office Phone #

List any allergies to medications

Are you currently?
☐Pregnant
☐Nursing

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

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

Have you had any of the following conditions?

☐Crossed Eyes	☐Drooping Eyelid	☐Glaucoma	☐Cataracts	☐Eye Injuries
☐Lazy Eye	☐Prominent Eyes	☐Retinal Disease	☐Eye Infections	

Please turn this form over and complete side two

Family History (relatives living or deceased)

	Relationship (mother, grandfather, etc.)		Relationship (mother, grandfather, etc.)
☐ Blindness		☐ Diabetes	
☐ Cataract		☐ Heart Disease	
☐ Crossed Eyes		☐ High Blood Pressure	
☐ Glaucoma		☐ Kidney Disease	
☐ Macular Degeneration		☐ Lupus	
☐ Retinal Detachment/Disease		☐ Thyroid Disease	
☐ Arthritis		☐ Other:	
☐ Cancer			

Social History *This information is kept strictly confidential; however, you may discuss this portion directly with the doctor if you prefer.*

Do you drive? ☐No ☐Yes

Do you have visual difficulty when driving? ☐No ☐Yes
If yes, please describe:

Do you?	Use tobacco products	Drink alcohol	Use cannabis products	Use illegal drugs
	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
	If yes, type/amount/how long:	If yes, type/amount/how long:	If yes, type/amount/how long:	If yes, type/amount/how long:

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 conditions in the following areas?

	Yes		Yes		Yes
Eyes		**Constitutional**		**Vascular/Cardiovascular**	
Loss of Vision	☐	Fever, Weight Loss/Gain	☐	Diabetes	☐
Blurred Vision	☐	**Integumentary** (Skin)	☐	Heart Pain	☐
Distorted Vision/Halos	☐	**Neurological**		High Blood Pressure	☐
Loss of Side Vision	☐	Headaches	☐	Vascular Disease	☐
Double Vision	☐	Migraines	☐	**Gastrointestinal**	
Dryness	☐	Seizures	☐	Diarrhea	☐
Mucous Discharge	☐	**Endocrine**		Constipation	☐
Redness	☐	Thyroid/Other Glands	☐	**Genito-Urinary**	
Sandy or Gritty Feeling	☐	**Ears, Nose, Mouth, Throat**		Genitals/Kidney/Bladder	☐
Itching	☐	Allergies/Hay Fever	☐	**Bones/Joints/Muscles**	
Burning	☐	Sinus Congestion	☐	Rheumatoid Arthritis	☐
Foreign Body Sensation	☐	Runny Nose	☐	Muscle Pain	☐
Excess Tearing/Watering	☐	Post-Nasal Drip	☐	Joint Pain	☐
Glare/Light Sensitivity	☐	Chronic Cough	☐	**Lymphatic/Hematologic**	
Eye Pain or Soreness	☐	Dry Throat/Mouth	☐	Anemia	☐
Chronic Infection of Eye or Lid	☐	**Respiratory**		Bleeding Problems	☐
Styes or Chalazion	☐	Asthma	☐	**Allergic/Immunologic**	☐
Flashes/Floaters in Vision	☐	Chronic Bronchitis	☐	**Psychiatric**	☐
Tired Eyes	☐	Emphysema	☐		

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

X

Patient's Signature

Date