Medical History Questionnaire

Name: _____ D.O.B.: _____/_____/_____

Address: _____ Phone: _____

City: _____ State:_____ Zip:_____ E-mail: _____

Employer: _____ Work Phone: _____

Work Address: _____Occupation: _____

Guardian (If Applicable): _____ Last Eye Exam _____/_____/_____

Social Security #: _____ Where did you purchase your last pair of glasses?_____

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

How did you hear about our office? _____ Last Medical Exam: _____

Medical History

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

_____

List and medications you take (including oral contraceptives, aspirin, over the counter medications, eye drops 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, eye surgery or eye injury: _____

_____

Are you pregnant and/or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes

Do you wear contacts? ☐ No ☐ Yes

Type of contacts: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ No ☐ Yes

Family History

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

Disease/ Condition	No	Yes	Relationship to you
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/ Disease	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other	☐	☐	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ☐ Yes, I prefer to discuss my Social History information directly with my 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/have you used illegal drugs? ☐ No ☐ Yes 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 problems in the following areas:

SYSTEM	No	Yes	?
CONSTITUTIONAL			
Fever, weight loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
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	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	No	Yes	?
EARS, NOSE, MOUTH, THROAT			
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	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/ Kidney/ Bladder	☐	☐	☐
BONES/ JOINTS? MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/ HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/ IMMUNOLOGICAL	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

_____

_____

_____

_____

_____

_____ _____

Patient's Signature **Date**