Medical History Questionnaire

Personal Information

Name: ______________________________________ Male or Female Today's Date _____/_____/_____

Address:____ Phone Number:_____________________________

City: ______________________Zip Code :_______________Alternate Phone:_______________________

Email____

Birth Date: _____/_____/_____ Social Security #:_____/_____/_____ Last Eye Exam: _____/_____/____

Widowed Married Single Other Age____ Date of Last Medical Exam_____/_____/_____

Guardian or Spouse:__________________________________ Employer:______________ __________________

Name of Medical Doctor:______________________________________ Dr.'s Phone__________________________

Insurance Information

Vision Insurance__________________ Policy Number __________________Policy Holder Name_______________

Policy Holder Birthdate_____________ Relationship to Patient______________

Medical Information

Do you have any allergies to medications? No Yes If yes, explain____________________________________

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

____

____

List all major injuries, surgeries, and hospitalizations you have had in the last 10 years:

____

Circle any of the following that you have had: Crossed Eyes Lazy Eye Drooping Eye Lid Cataracts
Prominent Eyes Glaucoma Retinal Disease Eye Infections Eye Surgery Eye Injury

Are you Pregnant or Nursing? YES NO
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, how old is your current pair of lenses?_________
Type of contacts (circle one) Rigid Soft Extended Wear Other Are they comfortable?_______

Family History

Please note any family history (parents, grandparents, siblings, children, aunts, uncles, or distant relatives)

Blindness	NO	YES	Relationship to you:____
Cataract	NO	YES	Relationship to you:____
Crossed Eyes	NO	YES	Relationship to you:____
Glaucoma	NO	YES	Relationship to you:____
Macular Degeneration	NO	YES	Relationship to you:____
Retinal Detachment	NO	YES	Relationship to you:____
Arthritis	NO	YES	Relationship to you:____
Cancer	NO	YES	Relationship to you:____
Diabetes	NO	YES	Relationship to you:____
Heart Disease	NO	YES	Relationship to you:____
High Blood Pressure	NO	YES	Relationship to you:____
Kidney Disease	NO	YES	Relationship to you:____
Lupus	NO	YES	Relationship to you:____
Thyroid Disease	NO	YES	Relationship to you:____
Other_____________	NO	YES	Relationship to you:____

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<u>Social History</u> *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 my doctor. (Circle one) YES NO

Do you drive? YES NO If yes, do you have visual difficulty while driving? YES NO
Do you use tobacco products? Yes NO If yes, type/amount/how long? _________________________
Do you drink alcohol? YES NO If yes, type/amount/how long? _________________________
Do you use illegal drugs? YES NO If yes, type/amount/how long? _________________________
Have you ever been exposed to or infected with: (circle one) Gonorrhea Hepatitis HIV Syphilis

<u>Review of Systems</u>
Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL		
Fever, Weight Loss/Gain	YES	NO
INTEGUMENTARY (Skin)	YES	NO
NEUROLOGICAL		
Headaches	YES	NO
Migraines	YES	NO
Seizures	YES	NO
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	YES	NO
Styes or Chalazion	YES	NO
Flashes/Floaters in Vision	YES	NO
Tired Eyes	YES	NO
ENDOCRINE		
Thyroid/Other Glands	YES	NO

EAR / NOSE / THROAT / MOUTH		
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
RESPIRATORY		
Asthma	YES	NO
Chronic Bronchitis	YES	NO
Emphysema	YES	NO
VASCULAR / CARDIOVASCULAR		
Diabetes	YES	NO
Heart Pain	YES	NO
Vascular Disease	YES	NO
GASTROINTESTINAL		
Diarrhea	YES	NO
Constipation	YES	NO
GENITOURINARY		
Genitals/Kidney/Bladder	YES	NO
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	YES	NO
Muscle Pain	YES	NO
Joint Pain	YES	NO
LYMPHATIC / HEMATOLOGIC		
Anemia	YES	NO
Bleeding Problems	YES	NO
ALLERGIC / IMMUNOLOGIC	YES	NO
PSYCHIATRIC	YES	NO

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