MEDICAL HISTORY QUESTIONAIRE

Name: _____ Today's Date: _____

Spouse / Parent's Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ E – Mail: _____

Birth Date: _____ - _____ - _____ Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Employer: _____ Occupation: _____

Vision Insurance: _____ Acct / Policy # _____

Whom may we thank for referring you to our office? _____

How will you settle your account today? _____ cash _____ check _____ credit card _____ insurance

Medical History

Name of Medical Doctor: _____ Last Physical: _____

Name of Eye Doctor: _____ Last Eye Exam: _____

Do you have any allergies to medications? ____ no ____ yes 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: _____

_____

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? ____ yes ____ no

Do you wear glasses? ____ yes ____ no If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ____ yes ____ no If yes, how old is your present pair of lenses? _____

Type of contact lenses: ____ Rigid ____ Soft ____ Extended Wear ____ Other Are they comfortable? ____ yes ____ no

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	_____	_____	_____
Arthritis	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Lupus	_____	_____	_____
Thyroid Disease	_____	_____	_____
Other	_____	_____	_____

Please turn this form over and complete side two

Social History:

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.
____ Yes, I would prefer to discuss my Social History information directly with my doctor.

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- ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

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 Sensation	____	____
Eye Pain or Soreness	____	____
Chronic Infection of Eye or Lid	____	____
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		
Genitals / Kidney / Bladder	____	____
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	____	____
Muscle Pain	____	____
Joint Pain	____	____
LYMPHATIC / HEMATOLOGIC		
Anemia	____	____
Bleeding Problems	____	____
ALLERGIC / IMMUNOLOGIC	____	____
PSYCHIATRIC	____	____

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

_____

_____

_____

_____ Doctor's Signature

_____ Date

Reviewed and updated _____ date _____ initials

Reviewed and updated _____ date _____ initials

Reviewed and updated _____ date _____ initials