Medical History Questionnaire

Name: Mr. Ms. _____ Today's Date: _____/_____/_____

E-Mail address: _____ (to be able to send you appointment reminders, promotions, etc.)

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

Reason for Visit:

_____

Medical History

Do you have any allergies to medications? □ No □ Yes If yes, please 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: _____

_____

Circle any of the following that you have had: Crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury, eye surgery. Please describe:_____

_____

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

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 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 complete the back side of this form.

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. (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: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM		NO	YES	?
ALLERGIES		☐	☐	☐
CARDIOVASCULAR	(**High blood pressure**, heart pain, vascular disease, etc.)	☐	☐	☐
CONSTITUTUTIONAL	(Fever, weight loss/gain, fatigue, nausea, sleep problem, etc.)	☐	☐	☐
ENDOCRINE	(**Diabetes**, high cholesterol, gout, thyroid, other glands, etc.)	☐	☐	☐
GASTROINTESTINAL	(Reflux, diarrhea, constipation, ulcer, gall bladder, etc.)	☐	☐	☐
GENITOURINARY	(Genitals, kidney, bladder, prostate, STD, etc.)	☐	☐	☐
EARS, NOSE, MOUTH, THROAT	(Chronic cough, dry mouth, sinus congestion, etc.)	☐	☐	☐
HEMATOLOGIC / LYMPHATIC	(Anemia, bleeding, leukemia, sickle cell, etc.)	☐	☐	☐
IMMUNOLOGIC	(Immunodeficiency, HIV, herpes, tuberculosis, etc)	☐	☐	☐
INTEGUMENTARY (SKIN)	(Acne, dermatitis, basal cell, psoriasis, etc.)	☐	☐	☐
MUSCULOSKELETAL	(**Rheumatoid arthritis**, muscle pain, joint pain, etc.)	☐	☐	☐
NEUROLOGICAL	(**Headaches**, **migraines**, seizures, brain disorder, etc.)	☐	☐	☐
PSYCHIATRIC		☐	☐	☐
RESPIRATORY	(Asthma, chronic bronchitis, lung disease, emphysema, etc.)	☐	☐	☐

EYES	NO	YES	?		NO	YES	?
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 of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Flashes in Vision	☐	☐	☐
Floaters in Vision	☐	☐	☐	Tired Eyes	☐	☐	☐

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

_____

_____

_____

_____

_____