Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ / _____

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

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

Last Medical Exam: _____ / _____ / _____

Medical History

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? ☐ 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 _____	☐	☐	☐	

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

Please turn this form over and complete side two

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain & list medications)

SYSTEM	NO	YES	?	EXPLAIN / LIST MEDICATIONS
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 of Eye or Lid	☐	☐	☐	
Sties or Chalazion	☐	☐	☐	
Flashes/Floaters in Vision	☐	☐	☐	
Tired Eyes	☐	☐	☐	
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	☐	☐	☐	
ENDOCRINE (thyroid/other glands)	☐	☐	☐	
ALLERGIC / IMMUNOLOGIC	☐	☐	☐	
PSYCHIATRIC	☐	☐	☐	

Doctor's Signature

Date