

## Medical History

### Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Dr. Phone: \_\_\_\_\_

Name of Medical Dr.: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

#### MEDICAL HISTORY

Do you have any allergies to medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, explain: \_\_\_\_\_

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

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List all major injuries, surgeries and/or hospitalizations you have had:

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Have you ever had any of the following: (Please circle)		crossed eyes	lazy eye	glaucoma	cataracts
drooping eyelid	prominent eye	retinal disease	eye infections	eye injury	
Are you pregnant or nursing?		No	Yes		
Do you wear glasses?		No	Yes	If yes, how old are your present pair of glasses?	
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?
				No	Yes

#### FAMILY HISTORY

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

Disease/Condition	Please circle appropriate answer			Relationship to You
Blindness	No	Yes	?	_____
Cataracts	No	Yes	?	_____
Crossed Eyes	No	Yes	?	_____
Glaucoma	No	Yes	?	_____
Macular Degeneration	No	Yes	?	_____
Retinal Detachment/Disease	No	Yes	?	_____
Arthritis	No	Yes	?	_____
Cancer	No	Yes	?	_____
Diabetes	No	Yes	?	_____
Heart Disease	No	Yes	?	_____
Lupus	No	Yes	?	_____
Kidney Disease	No	Yes	?	_____
Thyroid Disease	No	Yes	?	_____
High Blood Pressure	No	Yes	?	_____
Other	No	Yes	?	_____

**Please turn 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.*

Do you drive? No Yes If yes, do you have visual difficulty when driving? Yes No 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	Please circle appropriate answer			SYSTEM	Please circle appropriate answer			
<b>CONSTITUTIONAL</b>			<b>EARS, NOSE, MOUTH, THROAT</b>					
Fever, weight loss/gain	NO	YES	?	Allergies/Hay Fever	NO	YES	?	
<b>INTEGUMENTARY (skin)</b>	NO	YES	?	Sinus Congestion	NO	YES	?	
<b>NEUROLOGICAL</b>			Runny Nose			NO	YES	
Headaches	NO	YES	?	Post-Nasal Drip	NO	YES	?	
Migraines	NO	YES	?	Chronic Cough	NO	YES	?	
Seizures	NO	YES	?	Dry Throat/Mouth	NO	YES	?	
<b>EYES</b>			<b>RESPIRATORY</b>					
Loss of Vision	NO	YES	?	Asthma	NO	YES	?	
Blurred Vision	NO	YES	?	Chronic Bronchitis	NO	YES	?	
Distorted Vision/Halos	NO	YES	?	Emphysema	NO	YES	?	
			<b>VASCULAR/ CARDIOVASCULAR</b>					
Loss of Side Vision	NO	YES	?	Diabetes	NO	YES	?	
Double Vision	NO	YES	?	Heart Pain	NO	YES	?	
Dryness	NO	YES	?	High Blood Pressure	NO	YES	?	
Redness	NO	YES	?	Vascular Disease	NO	YES	?	
Mucous Discharge	NO	YES	?	<b>GASTROINTESTINAL</b>				
Sandy or Gritty Feeling	NO	YES	?	Diarrhea	NO	YES	?	
Itching	NO	YES	?	Constipation	NO	YES	?	
Burning	NO	YES	?	<b>GENITOURINARY</b>				
Foreign Body Sensation	NO	YES	?	Genitals/Kidney/Bladder	NO	YES	?	
Excess Tearing/Watering	NO	YES	?	<b>BONES/Joints/MUSCLES</b>				
Glare/Light Sensitivity	NO	YES	?	Rheumatoid Arthritis	NO	YES	?	
Eye Pain/Soreness	NO	YES	?	Muscle Pain	NO	YES	?	
Chronic Infection of Eye/Lid	NO	YES	?	Joint Pain	NO	YES	?	
Sties or Chalazion	NO	YES	?	<b>LYMPHATIC/HEMATOLOGIC</b>				
Flashes/Floater's in Vision	NO	YES	?	Anemia	NO	YES	?	
Tired Eyes	NO	YES	?	Bleeding Problems	NO	YES	?	
<b>ENDOCRINE</b>			<b>ALLERGIC/IMUNOLOGIC</b>					
Thyroid/Other Glands	NO	YES	?	<b>PHYSIATRIC</b>			NO	YES

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

Dr. Signature:

Date: