SOUTH PASADENA OPTOMETRIC GROUP

729 Mission St. Suite 200 South Pasadena, CA 91030

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____ / _____ / 20_____

Eye History Last Eye Exam: _____ mo / _____ yr

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

Other Eye History _____

Medical History Last Medical Exam: _____ mo / _____ yr

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

_____

Are you pregnant and/or nursing? ❒ no ❒ yes

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

_____

_____

Do you have any allergies to medications? ❒ no ❒ yes If yes, list them: _____

Personal and Family History

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

DISEASE/CONDITION	NO	YES	?	WHO? (SELF, PARENTS, SIBLINGS…)
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Cross Eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Headaches	❒	❒	❒	_____
Seizures	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
High Blood Pressure	❒	❒	❒	_____
Hepatitis	❒	❒	❒	_____
HIV-positive	❒	❒	❒	_____
Lupus	❒	❒	❒	_____
Rheumatoid Arthritis	❒	❒	❒	_____
Thyroid Disease	❒	❒	❒	_____
Psychiatric	❒	❒	❒	_____
Other	❒	❒	❒	_____

Social History (*This information is kept strictly confidential You may discuss this portion directly with the doctor if you prefer.*

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: _____