Medical History Questionnaire

Name: _____ Sex: M F Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____Work / Cell: _____

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

Email address: _____

Occupation: _____ Marital Status: _____

Medical Doctor: _____ Phone:_____ Last Exam: _____

Medical History

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

_____

List any medications you take (including oral contraceptives, eye drops, 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 or eye injury**: List any other eye conditions not listed: _____

_____

Are you pregnant and/or nursing? no yes

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

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

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

Do you plan on getting new glasses or contact lenses today? yes no maybe

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.

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:

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain			
INTEGUMMENTARY (Skin)			
NEUROLOGICAL			
Headaches			
Migraines			
Seizures			
EYES			
Loss of Vision			
Blurred Vision			
Distorted Vision / Halos			
Dry Eyes			
Redness			
Mucous/Discharge			
Double Vision			
Loss of Side Vision			
Sandy or Gritty Feeling			
Itching			
Excess Tearing / Watering			
Glare / Light Sensitivity			
Foreign Body Sensation			
Burning			
Eye Pain or Soreness			
Chronic Infection of Eye or Lid			
Styes 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			
Emphysema			
Chronic Bronchitis			
VASCULAR / CARDIOVASCULAR			
Diabetes			
High Blood Pressure			
Heart Pain			
Vascular Disease			
Stroke			
GASTROINTESTINAL			
Constipation			
Diarrhea			
GENITOURINARY			
Genital / Kidney / Bladder			
MUSCULARSKELETAL			
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:

_____

_____

_____

_____

X_____ _____ _____

Patient's Signature **Date** Parent or Guardian's Signature