Medical History Questionnaire

Today's Date: ___ / ___ / ___

Name: _____ Birth Date: _____ / _____ / _____

Address: _____ Social Security #: _____

_____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

Name of Medical Doctor: _____ Last Medical Exam: _____ / _____ / _____

Name of Previous Eye Doctor: _____ Last Eye Exam: _____ / _____ / _____

Ocular / Medical History

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, what type? ☐ RGP ☐ Soft Do you sleep in them? ☐ No ☐ Yes

How frequently do you replace them? _____ Are they comfortable? ☐ Yes ☐ No

Are you currently experiencing any of the following problems with your eyes? **Check the box if "*Yes*."**

- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Loss of Side Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Tired Eyes
- ☐ Flashes / Floaters in Vision
- ☐ Halos
- ☐ Glare / Light Sensitivity
- ☐ Dryness
- ☐ Sandy or Gritty Feeling
- ☐ Foreign Body Sensation
- ☐ Burning
- ☐ Itching
- ☐ Redness
- ☐ Excess Tearing / Watering
- ☐ Eye Pain or Soreness
- ☐ Mucous Discharge
- ☐ Chronic Infection of the Eye or Eyelid
- ☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? **Check the box if "*Yes*."**

- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Drooping eyelid
- ☐ Other: _____

List any **medications** you are currently taking (include oral contraceptives, aspirin, over the counter medications, and home remedies):

_____

_____

_____

Are you **allergic** to any medications? ☐ No ☐ Yes If yes, please explain: _____

_____

List all major **surgeries** and/or **hospitalizations** you have had: _____

_____

Family History

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

	RELATION TO YOU		RELATION TO YOU
☐ Blindness	_____	☐ Cancer	_____
☐ Cataract	_____	☐ Diabetes	_____
☐ Crossed Eyes	_____	☐ Heart Disease	_____
☐ Glaucoma	_____	☐ High Blood Pressure	_____
☐ Macular Degeneration	_____	☐ Kidney Disease	_____
☐ Retinal Detachment	_____	☐ Lupus	_____
☐ Arthritis	_____	☐ Thyroid Disease	_____

*** Please turn this form over and complete side two ***

Review of Systems

Please check the box beside any problem you currently have, or have ever had, in the following areas:

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy / Hayfever

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

ENDOCRINE ☐ All Normal
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY (SKIN) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL ☐ All Normal
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

_____

_____

_____

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

Social History

*This information is kept strictly confidential. However, **you may discuss this portion directly with your doctor if you prefer**. Please check the following box if you wish to discuss your Social History directly with your doctor:* ☐

Do you drive? ☐ No ☐ Yes If yes, describe any visual difficulty while driving: _____

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: _____

Indicate by checking the box if you have been infected with or exposed to: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

For Doctor's Use Only:

_____ _____

Doctor's Signature Date