

Medical History Questionnaire

Name: _____ Today's Date: ___ / ___ / ___
 Address: _____ Phone: _____
 _____ Cell Phone: _____
 Birth Date: ___ / ___ / ___ Social Security #: ___ / ___ / ___ Last Eye Exam: ___ / ___ / ___
 Email: _____ Last Medical Exam: ___ / ___ / ___
 Name of Medical Doctor: _____ Dr.'s Phone: _____

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 & 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 are your present pair of lenses? _____
 Do you wear contact lenses? No Yes If yes, how old are your present pair of lenses? _____
 Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No

Family History:

Please not any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	NO	YES	?	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two

Social History: *This information is kept strictly confidential. However you may discuss this portion 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 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 had any problems in the following areas:

<u>System:</u>	NO	YES	?		NO	YES	?
Constitutional:							
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Integumentary (Skin):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Neurological:							
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eyes:							
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Endocrine:							
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Ears, Nose, Mouth, Throat:							
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Respiratory:							
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Vascular/Cardiovascular:							
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Gastrointestinal:							
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Genitourinary:							
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bones/Joints/Muscles:							
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Lymphatic/Hematologic							
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

Print Name (Patient, Parent/Guardian)

Date