Medical History Questionnaire

Name _____ Today's Date _____/_____/_____

Birth Date _____/_____/_____ Age _____ Social Security # _____/_____/_____ Last Eye Exam _____/_____/_____

Name of Medical Doctor _____ Dr's Phone _____ Last Med Exam _____/_____/_____

Home Phone No. _____ Work Phone No. _____

E-Mail Address: _____ State of Birth: _____

Home Address: Street _____ City _____ State _____ Zip _____

Legal Guardian or Spouse _____ Emergency Phone No. _____

Patient's Employer _____ Position/Type Work _____

Spouse's Employer _____

Insurance: Insurance Holder Self ☐ Spouse ☐ Insurance No. _____ Medicaid ☐ Medicare☐
Insurance Holder's Date of Birth: _____

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 and home remedies)
_____
_____

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

List any of the following you have had: crossed eyes, lazy eye, drooping eye, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant or nursing? No ☐ Yes ☐

Do you wear glasses? No ☐ Yes ☐ If yes, how old is your present pair of lenses? _____

Do you wear contacts? 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	No	Yes	?	Relationship to You
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retina Detachment/ Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart 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, prefer to discuss my social history information directly with my doctor. (check box).

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe: _____
_____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/ amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/ how long: _____

Do you use illegal drugs? ☐ Yes ☐ No 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: (If YES, explain and list medications)

SYSTEM	NO	YES	?	EXPLAIN/LIST MEDICATIONS
CONSTITUTIONAL (fever, weight loss/gain)	□	□	□	_____
INTEGUMENTARY (skin)	□	□	□	_____
NEUROLOGICAL				
Headaches	□	□	□	_____
Migraines	□	□	□	_____
Seizures	□	□	□	_____
EYES				
Loss of Vision	□	□	□	_____
Blurred Vision	□	□	□	_____
Distorted Vision/Halos	□	□	□	_____
Double Vision	□	□	□	_____
Dryness	□	□	□	_____
Mucous Discharge	□	□	□	_____
Redness	□	□	□	_____
Sandy or Gritty Feeling	□	□	□	_____
Itching	□	□	□	_____
Burning	□	□	□	_____
Foreign Body Sensation	□	□	□	_____
Excess Tearing/Watering	□	□	□	_____
Glare/Light Sensitivity	□	□	□	_____
Eye Pain or Soreness	□	□	□	_____
Chronic Infection of Eye or Lid	□	□	□	_____
Sties or Chalazion	□	□	□	_____
Flashes/Floaters in Vision	□	□	□	_____
Tired Eyes	□	□	□	_____
EARS, NOSE, MOUTH, THROAT				
Allergies/Hay Fever	□	□	□	_____
Sinus Congestion	□	□	□	_____
Runny Nose	□	□	□	_____
Post-Nasal Drip	□	□	□	_____
Chronic Cough	□	□	□	_____
Dry Throat/Mouth	□	□	□	_____
RESPIRATORY				
Asthma	□	□	□	_____
Chronic Bronchitis	□	□	□	_____
Emphysema	□	□	□	_____
VASCULAR/CARDIOVASCULAR				
Diabetes	□	□	□	_____
Heart Pain	□	□	□	_____
High Blood Pressure	□	□	□	_____
Vascular Disease	□	□	□	_____
GASTROINTESTINAL				
Diarrhea	□	□	□	_____
Constipation	□	□	□	_____
GENITOURINARY (genitals/kidney/bladder)	□	□	□	_____
BONES/MUSCLES/JOINTS				
Rheumatoid Arthritis	□	□	□	_____
Muscle Pain	□	□	□	_____
Joint Pain	□	□	□	_____
LYMPHATIC/HEMATOLOGIC				
Anemia	□	□	□	_____
Bleeding Problems	□	□	□	_____
ENDOCRINE (thyroid/other glands)	□	□	□	_____
ALLERGIC/IMMUNOLOGIC	□	□	□	_____
PSYCHIATRIC	□	□	□	_____

Date _____

Patient's Signature _____ Doctor's Signature _____