Medical History Questionnaire

Name: _____ **Sex: M / F** **Age:** _____ **Today's Date:** _____/_____/_____

Guardian (If Applicicable): _____ **Occupation:** _____ **If a Student , What Grade:** _____

Last Eye Exam: _____/_____/_____ **By:**_____ **Family Doctor:**_____ **LastMedical Exam:** _____/_____/_____

Vision Insurance: _____ **Medical Insurance:**_____

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 eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or injury: _____

Are you pregnant or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of glasses? _____
Do you wear contacts? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ☐ Rigid ☐ Soft Do you sleep in your lenses? ☐ no ☐ yes If so, how many days? _____
How often do you replace your lenses? _____ Are you lenses comfortable? ☐ no ☐ yes Are they dry by days end? ☐ no ☐ yes

Family History

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

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment / Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	

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

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. (Check Box)

Do you drive? ☐ no ☐ yes If yes, do you have any visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

_____

Do you use tobacco products? ☐ no ☐ yes Do you drink alcohol? ☐ no ☐ yes If yes, how much:_____

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:

SYSTEMS	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema / Psoriasis	☐	☐	☐
Rosacea	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
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	☐	☐	☐
ENDOCRINE			
Thyroid Dysfunction	☐	☐	☐
Hormonal Dysfunction	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
Panic Disorder	☐	☐	☐

SYSTEMS	NO	YES	?
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	☐	☐	☐
Stroke	☐	☐	☐
GASTROINTESTINAL			
Crohn's / Colitis	☐	☐	☐
Ulcer / Digestive	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
High Cholesterol	☐	☐	☐
ALLERGIC / IMMUNOLOGIC			
Drug Allery	☐	☐	☐
Environmental Allergies	☐	☐	☐

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

_____

_____

_____

_____