Medical History Questionnaire

Name:_____ Today's Date_____
Address:_____ Phone:_____
City/State/Zip:_____ Work Phone:_____
Email Address:_____(for recall purposes only)
Birth Date:____/_____/_____ Social Security #:_____-_____-_____ Last Eye Exam:_____/_____/_____
Emergency Contact:_____ Phone:_____
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 and 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, cataract, eye infections or eye injury:_____

Are you pregnant and/or nursing? ____ no ____ yes
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, how old is your present pair of lenses? _____
Type of contact lenses: ____Rigid ____Soft ____Extended Wear ____Other Are they comfortable?_____

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 Eye	____	____	____	_____
Glaucoma	____	____	____	_____
Macular degeneration	____	____	____	_____
Retinal Detachment/Disease	____	____	____	_____
Arthritis	____	____	____	_____
Cancer	____	____	____	_____
Diabetes	____	____	____	_____
Heart Disease	____	____	____	_____
High Blood Pressure	____	____	____	_____
Kidney Disease	____	____	____	_____
Lupus	____	____	____	_____
Thyroid Disease	____	____	____	_____

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 difficulty when driving? ____no ____yes

If yes, please explain_____

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 or infected with: ____Gonorrhea ____Hepatitis ____HIV ____Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	____	____	____
INTEGUMENTARY(Skin)	____	____	____
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/Lid	____	____	____
Sties or Chalazion	____	____	____
Flashes/Floaters in Vision	____	____	____
Tired Eyes	____	____	____
ENCOCRINE			
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	____	____	____
Chronic Bronchitis	____	____	____
Emphysema	____	____	____
VASCULAR/CRADIOVASCULAR			
Diabetes	____	____	____
Heart Pain	____	____	____
High Blood Pressure	____	____	____
Vascular Disease	____	____	____
GASTROINTESTINAL			
Diarrhea	____	____	____
Constipation	____	____	____
GENITOURINARY			
Genitals/Kidney/Bladder	____	____	____
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	____	____	____
Muscle Pain	____	____	____
Joint Pain	____	____	____
LYMPHATIC/HEMATOLOGIC			
Anemia	____	____	____
Bleeding Problems	____	____	____
ALLERGIC/IMMUNOLOCIC	____	____	____
PSYCHIATRIC	____	____	____

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

_____

_____

_____

_____

_____

Doctor's initials:_____ Date:_____