Medical History Questionnaire

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. _____ Today's Date: ___/___/___

Street: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Birth Date: ___/___/___ Social Security #: ___/___/___ Work Phone: _____

Name of Medical Doctor: _____ Email Address: _____

Last Eye Exam: ___/___/___ From Dr.: _____ Last Medical Exam: ___/___/___

Occupation: _____ Employer: _____

Optical Insurance Co.: _____ ID #: _____

Policy Holders Name: _____ DOB ___/___/___ Relationship to Patient: _____

Medical Insurance: _____ ID#: _____

Policy Holders Name: _____ DOB ___/___/___ Relationship to Patient: _____

Supplemental: _____

How did you hear about us: Friend _____ Internet _____ Walk In _____ Other _____

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 supplements): _____

List all major eye injuries and/or surgeries you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts or eye infections.

Are you a diabetic? ❑ no ❑ yes Are you on insulin? ❑ no ❑ yes Last Blood Sugar _____

Are you pregnant and/or nursing? ❑ no ❑ yes A1C %_____ Avg. Blood Sugar _____

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 you considering contacts? ❑ 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	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other	❑	❑	❑	

(over)

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 visual difficulty when driving? ❑ no ❑ yes If yes, please describe: _____

_____

Are you a current smoker? ❑ no ❑ yes type/how long: _____

Are you a past smoker? ❑ no ❑ yes quit date: _____

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 ❑ Herpes ❑ HIV ❑ Syphilis

Review of Systems

Do you currently, or have you ever had chronic 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	❑	❑	❑
ENDOCRINE			
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 / CARDIOVASCULAR			
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 / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

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

_____

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date