MEDICAL HISTORY QUESTIONNAIRE

Today's Date _____/_____/_____

Patient's Legal Name: _____ Patient's D.O.B. _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #'s HM: _____ Office: _____ Cell: _____ Do you accept texts for reminders? ❑ No ❑ Yes

Email _____

Date of Last Eye Exam: ____/____/_____ Was last eye exam here? ❑ No ❑ Yes If No, Dr's Name: _____

Name of Medical Doctor: _____ Dr.'s Phone: (_____) _____ - _____

Last Medical Exam: ____/____/_____ Preferred Language: (circle one please) English / Spanish

Race: (circle one please) American Indian or Alaska Native / Asian / Black or African American / Hispanic / Native Hawaiian or Other Pacific Island / White

Medical History

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain: _____

_____

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

_____

List all injuries, surgeries, hospitalizations you have had: _____

_____

Are you pregnant? ❑ No ❑ Yes If no, are you trying to become pregnant? ❑ No ❑ Yes Are you 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? ❑ No ❑ Yes

Family History

Please note any family history (parents, grandparents, siblings; 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_____	☐	☐	☐	_____

Please turn this form over and complete side two

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	❑	❑	❑
Multiple Sclerosis	❑	❑	❑
Parkinson's Disease	❑	❑	❑
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/Other Glands	❑	❑	❑

SYSTEM	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	❑	❑	❑
Elevated Cholesterol	❑	❑	❑
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	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain & list medications along with their dosages & frequency (including eye drops, oral contraceptives, aspirin, over the counter, home remedies and supplements):

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

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:

Do you use tobacco products? ❑ no ❑ yes If yes, type/amount/how long: _____

If no, have you ever? ❑ no ❑ yes Date quit: _____

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 ❑ No

Have you ever had a blood transfusion? ❑ no ❑ yes