MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

FULL NAME: _____ TODAY'S DATE_____/_____/_____
ADDRESS: _____ PHONE: _____
CITY, STATE ZIPCODE:_____ CELL: _____
BIRTH DATE: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ SEX: _____MALE _____FEMALE
E-MAIL_____ LAST MEDICAL EXAM: _____ LAST EYE EXAM: _____/_____
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(Please Circle):* Cell Home Phone Email Text Message
MEDICAL DOCTOR:_____ PREVIOUS EYE DR._____
MARITAL STATUS: _____ SPOUSE'S NAME_____
NAMES OF CHILDREN IN LIVING IN YOUR HOUSEHOLD_____
OCCUPATION:_____ ___FULL TIME___PART TIME___RETIRED ___STUDENT SCHOOL:_____
EMPLOYER:_____ WORK PHONE:_____
VISION INSURANCE_____ PRIMARY MEDICAL INSURANCE_____
HOW DID YOU HEAR ABOUT OUR OFFICE? (Please Circle) Insurance website Google Yahoo Walk By Referral
*WHO MAY WE THANK FOR REFERRING YOU?*_____

MEDICAL HISTORY

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):_____
_____
Do you have any environmental allergies or allergies to medications? ___YES___NO If yes, what type of reaction: _____
_____
List all major injuries, surgeries and/or hospitalizations:_____
_____
Have you been diagnosed with any eye conditions in the past, included, but not limited to the following: glaucoma, retinal disease, cataracts, eye infection or eye injury, contact lens complication crossed eye/strabismus, lazy eye
_____
Do you wear glasses? ____YES ____NO If yes, how old is your present pair?_____
Do you wear contacts? ____YES ____NO If yes, what type do you wear?_____

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	□	□	_____
Cataracts	□	□	_____
Crossed Eyes	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment/Disease	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Autoimmune Disease	□	□	_____
Thyroid Disease	□	□	_____
Other _____	□	□	_____

Please turn over and complete the other side

SOCIAL HISTORY

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

_____

Do you smoke or use tobacco products? □ no □ yes If yes, amount? How many years? If no, when did you quit?

_____

Do you drink alcohol? □ no □ yes If yes, amount? _____

Do you use illegal drugs? □ no □ yes If yes, what type? Amount? How many years? _____

REVIEW OF SYSTEMS

Do you currently or have 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/Soreness		□	□ □
Chronic Infection of Eye or Lid		□	□ □
Chronic Stye/Chalazion		□	□ □
Flashes/Floaters in Vision		□	□ □
Tired Eyes		□	□ □
ENDOCRINE			
Thyroid Dysfunction		□	□ □
Other Gland Dysfunction		□	□ □

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		□	□ □
Heart Pain			□ □ □ □
High Blood Pressure		□	□ □
Vascular Disease			□ □ □ □
GASTROINTESTIONAL			
Diarrhea		□	□ □
Constipation		□	□ □
GENITOURINARY			
Kidney/Bladder		□	□ □
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis		□	□ □
Osteoarthritis		□	□ □
Muscle/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:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date