

# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

Guardian (If Applicable): \_\_\_\_\_ Occupation: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Eye Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_

Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 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, cataracts, 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?  yes  no

## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\* 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 visual difficulty when driving?  no  yes If yes, please describe:

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 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:

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 or Lid

Sites 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

Heart Pain

High Blood Pressure

Vascular Disease

### GASTROINTESTINAL

Diarthra

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