VISION ASSOCIATES OF HACKETTSTOWN

Dr. Jeanine Jacco Labrada
915 Rt. 517, Unit B16
Hackettstown, NJ 07840

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date _____

Address: _____ Phone: (Home #): _____

_____ (Work #): _____

Email Address: _____ (Cell #): _____

Preferred Method of Contact (√): Phone - Home _____ Work _____ Cell _____ Text _____ Email _____

Guardian (If Applicable): _____ (Occupation): _____

Date of Birth: ____ /____ /_____ Social Security Number: ____ /____ /_____ Date Last Eye Exam: ____ /____ / _____

Medical Doctor: _____ Dr.'s Phone: _____ Date Last 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 any major injuries, surgeries and / or hospitalizations you have had: _____

_____

List any of the following that you have had: Crossed eyes, lazy eye(s), drooping eyelid, prominent eye(s), glaucoma, retinal disease, cataracts, eye infections or eye injury:

_____

Are you pregnant or nursing? _____ No _____Yes

Do you wear glasses? _____ No _____Yes If yes, how old is your current pair of lenses?_____

Do you wear contact lenses? _____ No _____Yes If yes, how old is your current 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	Don't know	Relationship to You
Blindness				
Cataract				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment / Disease				
Arthritis				
Diabetes				
Cancer				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease				
Other				

(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 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 with 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 or Watering			
Glare/Light Sensitivity			
Eye Pain or Soreness			
Chronic Infection or 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/Cardio Vascular			
Diabetes			
Heart Pain			
High Blood Pressure			
Vascular Disease			
Gastrointestinal			
Diarrhea			
Constipation			
Genitourinary			
Genitals/Kidney/Bladder			
Bone/Joint/Muscles			
Rheumatoid Arthritis			
Muscle Pain			
Joint Pain			
Lymphatic/Hematologic			
Anemia			
Bleeding Problems			
Allergic/Immunologic			
Psychiatric			

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

_____

_____

_____ _____

Doctor's Signature Date