Precise Family Eyecare, P.C.

MEDICAL HISTORY QUESTIONNAIRE

The information you provide below is important to your exam. Please fill out this form in full to the best of your ability.

Please list any allergies to medication: _____
Please list all medications that you take (with dosage, if known) including oral contraceptives, aspirin, over-the-counter medications, vitamins, and home remedies: _____
_____
_____

Are you pregnant and/or nursing? ☐ Yes ☐ No

Have you ever worn glasses? ☐ Yes ☐ No Do you currently wear glasses? ☐ Yes ☐ No
How long? _____ How many pairs of glasses do you currently use? _____
Have you ever worn contact lenses? ☐ Yes ☐ No Do you currently wear contact lenses? ☐ Yes ☐ No
How long? _____ What brand of contact lenses have you worn most recently? _____

Please check any of these eye symptoms that you experienced recently:

☐ Blurry distance vision	☐ Blurry near vision	☐ Poor night vision	☐ Sensitivity to light	☐ Double vision
☐ Distorted vision/Halos	☐ Lose of side vision	☐ Floaters	☐ Flashes of light	☐ Dry eyes
☐ Eye pain/soreness	☐ Burning	☐ Watery eyes	☐ Itchy eye	☐ Red eyes
☐ Temporary blindness	☐ Mucous	☐ Feeling of something in the eye		☐ Other: _____

Social History
Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty while driving? ☐ Yes ☐ No
If so, please describe: _____
_____
Do you smoke? ☐ Yes ☐ No If yes, how much? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____
How many hours per day do you spend: on the computer? _____ reading? _____ outdoors? _____

Review of Systems: Do you or a family member have problems in the following areas, either currently or in the past? Please check all that apply. (Please note that "family" pertains to blood relatives only.) **S** - Self **F** - Family

	S	F		S	F		S	F		S	F
Ocular			*Constitutional*			*Gastrointestinal*	☐	☐	*Vascular/cardiovascular*		
glaucoma	☐	☐	fever/weight loss/gain	☐	☐	*Respiratory*			diabetes	☐	☐
lazy eye	☐	☐	*Skin (integumentary)*	☐	☐	asthma	☐	☐	heart pain	☐	☐
cataract	☐	☐	*Endocrine*			chronic bronchitis	☐	☐	high blood pressure	☐	☐
retinal disease	☐	☐	thyroid/other glands	☐	☐	emphysema	☐	☐	heart disease	☐	☐
macular disease	☐	☐	*Psychiatric*	☐	☐	*Bones/joints/muscles*			vascular disease	☐	☐
blindness	☐	☐	*Ears,nose,mouth,throat*			rheumatoid arthritis	☐	☐	brain injury/stroke	☐	☐
eye injury	☐	☐	allergies:seasonal	☐	☐	muscle pain	☐	☐	*Gastrointestinal*		
Neurological			sinus congestion	☐	☐	joint pain	☐	☐	nausea/diarrhea	☐	☐
headaches	☐	☐	runny nose/post-nasal drip	☐	☐	*Lymphatic/hematologic*			constipation	☐	☐
migraines	☐	☐	dry mouth/throat	☐	☐	anemia	☐	☐	other: _____	☐	☐
seizures	☐	☐	*Genitourinary*			bleeding problems	☐	☐	_____		
Cancer	☐	☐	kidney/bladder/genital	☐	☐	*Allergic:immunologic*	☐	☐	_____		

I hereby attest that the information I have provided on this form is complete and correct to the best of my knowledge:

Signature: _____ Today's Date: _____

Printed Name: _____ DOB: _____

FOR OFFICE USE ONLY – Doctor's Initial: _____