Medical History Questionnaire

What is the main reason for today's visit? _____

When was your last eye exam? ____yrs., Where? _____ and significant findings? _____

Hours spent on computer each day? _____hrs. is it ☐**Constant or** ☐**On/off**. Distance to monitor: _____inches

Please list all **Eye Drops or Ocular medications** currently taking:

_____

Please list all **Other/Oral** both prescribed and over-the-counter **Medications** currently taking:

_____

Please list all **Allergies** including medication allergies and reaction it causes:

_____

DISEASE/CONDITION Self or Family & RELATIONSHIP TO YOU: Please check all that applies to self or family

Eye Conditions	Self	Family	Relationship Onset	Medical Conditions	Self	Family	Relationship Onset
Cataracts	□	□	□adult □child	Diabetes	□	□	□adult □child
Glaucoma	□	□	□adult □child	High Blood Pressure	□	□	□adult □child
Macular Degen.	□	□	□adult □child	High Cholesterol	□	□	□adult □child
Color Blind	□	□	□adult □child	Hyperthyroid	□	□	□adult □child
Lazy/Eye Turn	□	□	□adult □child	Hypothyroid	□	□	□adult □child
Retinal Disease	□	□	□adult □child	Rheumatoid Arthritis	□	□	□adult □child

Please Specify any other **Eye Conditions** not listed above including history of eye injuries or surgeries:

_____

Please Specify any other **Medical Conditions** not listed above:

_____

Have you smoked in past 30 days? □**No** □**Yes** Have you used smokeless tobacco in past 30 days? □**No** □**Yes**

Alcohol? □**No** □**Yes -** □*mild* □*moderate/social* □*excess (>10/wk)* Other illegal drugs? □**No** □**Yes**

REVIEW OF SYSTEMS: Do **you** currently, or have **you** ever had any problems in the following areas:

GENERAL/CONSTITUTIONAL:	☐ weight loss/gain ☐ fever/chills ☐ insomnia
EARS, NOSE, MOUTH, THROAT:	☐ hay fever ☐ thrush ☐ mouth sores ☐ decreased hearing ☐ ear drainage
CARDIOVASCULAR:	☐ arrhythmia ☐ heart disease ☐ cholesterol ☐ pacemaker ☐ stint ☐ valve defect
RESPIRATORY:	☐ asthma ☐ bronchitis ☐ emphysema ☐ lung cancer ☐ pneumonia ☐ tuberculosis
GENITOURINARY:	☐ dialysis ☐ blood in urine ☐ hernia ☐ kidney stone ☐ menopause ☐ STD
MUSCULOSKELETAL:	☐ rheumatoid arthritis
INTEGUMENTARY:	☐ eczema ☐ rosacea ☐ hair and nail changes ☐ psoriasis
NEUROLOGICAL:	☐ dizziness/vertigo ☐ epilepsy ☐ seizures ☐ migraines ☐ paralysis ☐ tremor
PSYCHIATRIC:	☐ memory loss ☐ depression ☐ dementia
ENDOCRINE:	☐ heat/cold intolerance ☐ frequent urination ☐ chronic thirst
LYMPHATIC / HEMATOLOGIC:	☐ anemia ☐ bleeding problems ☐ leukemia
IMMUNOLOGIC:	☐ immune deficiency

Do you wear Contact Lenses? ☐No ☐Yes and what brand and power? _____

Please rate the following quality of your current contact lenses on a scale of 1 – 10, with 1 being POOR and 10 being EXCELLENT:

Lens Comfort: _____ (Right) _____ (Left) **Distance Vision:** _____ (Right) _____ (Left) **Near Vision:** _____ (Right) _____ (Left)

Please specify below any other concerns you'd like us to go over today: