ROSEVILLE OPTOMETRY ASSOCIATES

Medical History Questionnaire

Name_____ Today's Date _____

How did you hear about us?_____ When was your last eye exam?_____

Occupation?_____ Computer use hours a day?_____

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

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, explain: _____

List any medications you take (including aspirin, over the counter medications, vitamins/supplements & home remedies), and state reason for taking the medication:

1)_____ Reason_____ 5)_____ Reason _____

2)_____ Reason_____ 6)_____ Reason_____

3)_____ Reason_____ 7)_____ Reason_____

4)_____ Reason_____ 8)_____ Reason_____

Primary Care Doctor: _____

List major injuries and prior surgeries you have had:

_____

Are you pregnant or nursing? ☐ Yes ☐ No

Do you wear glasses? (check all that apply): ☐ None ☐ Reading ☐ Distance ☐ Computer

☐ Safety ☐ Sports ☐ Bifocals ☐ Trifocals ☐ Progressives (no-line)

Do you wear contact lenses? ☐ None ☐ Rigid ☐ Soft Lenses/Disposables

☐ Extended Wear Are they comfortable? ☐ Yes ☐ No

Type/Brand: _____

If using disposable lenses, how often do you discard them? *(ex: dispose every 2 weeks):*_____

What duration of time are contacts worn? *(ex: Mon-Fri from 6:30am-7:00pm):*_____

SOCIAL HISTORY

Hobbies/Interests:_____

Do you drive? ☐ Yes ☐ No

If yes, do you have visual difficulty when driving? (please specify):

_____

Do you use tobacco products? ☐ Yes ☐ No

If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, type/amount/how long? _____

Do you use illegal drugs? ☐ Yes ☐ No

If yes, type/amount/how long? _____

GENERAL HEALTH CONDITION

Do you have or ever had any problems in the following areas?

AIDS/HIV	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Allergies/Hay Fever	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No

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Asthma	☐ Yes	☐ No	Cholesterol	☐ Yes	☐ No
Thyroid Condition	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No

EYE HISTORY

Lasik/Refractive Surgery	☐ Yes	☐ No			
Loss of Vision	☐ Yes	☐ No	Excess Tearing/Watering	☐ Yes	☐ No
Blurred Vision Distance	☐ Yes	☐ No	Glare/Light Sensitivity	☐ Yes	☐ No
Blurred Vision Near	☐ Yes	☐ No	Eye Pain or Soreness	☐ Yes	☐ No
Loss of Side Vision	☐ Yes	☐ No	Chronic Infection Eye or Lid	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Sties or Chalazion	☐ Yes	☐ No
Dryness	☐ Yes	☐ No	Flashes/Floaters in Vision	☐ Yes	☐ No
Mucous Discharge	☐ Yes	☐ No	Tired Eyes	☐ Yes	☐ No
Redness	☐ Yes	☐ No	Cataracts	☐ Yes	☐ No
Sandy or Gritty Feeling	☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No
Itching	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Burning	☐ Yes	☐ No			

FAMILY HISTORY

To the best of your knowledge, please note any family history (parents, grandparents, siblings, children) for the following conditions:

Condition			***Relationship to You***
Eye Surgery	☐ Yes	☐ No	_____
Amblyopia (Lazy Eye)	☐ Yes	☐ No	_____
Blindness	☐ Yes	☐ No	_____
Color Blindness	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Strabismus (eye turn)	☐ Yes	☐ No	_____
Retinal Detachment	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Cholesterol	☐ Yes	☐ No	_____
Lupus	☐ Yes	☐ No	_____
Thyroid Disease	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____

If yes, state type of cancer: _____

Thank you for your confidence