Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____
Address: _____ Phone: _____
City: _____ Zip: _____ Work Phone: _____
Guardian (If Applicable): _____ Occupation: _____
Birth Date: _____/_____/_____SSN: _____/____/____ Last Eye Exam: _____/_____/_____
Name of Primary Medical Doctor: _____ Dr. Phone: _____
Email Address: _____ Last Medical Exam: _____/_____/_____
Height: _____ Weight: _____

MEDICAL HISTORY

Do you have any allergies to medications? (please circle) Yes No If yes, please 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: _____
_____

Circle any of the following that you have had: crossed eyes, lazy eye, dropping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: Other: _____

Are you pregnant and/or nursing? (please circle) Yes No
Do you wear glasses? Yes No If yes, how old are they? _____
Do you wear contact lenses? Yes No If yes, how old are they? _____
Type of contact lens? Rigid Soft 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	___	___	___	_____
Cataract	___	___	___	_____
Crossed Eyes	___	___	___	_____
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Detachment/Disease	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
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'd prefer to discuss with my doctor

Do you drive? (please circle) Yes No If yes, do you have visual difficulty when driving? Y/N If yes, describe:

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: _____

Have you ever been exposed to or infected with: (please circle) 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	___	___	___
Sties or Chalazion	___	___	___
Flashes/Floaters in Vision	___	___	___
Tired Eyes	___	___	___
ENDOCRINE			
Thyroid/Other Glands	___	___	___
ALLERGIC/IMMUNOLOGIC	___	___	___

SYSTEM	**NO**	**YES**	**?**
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	___	___	___
Sinus Congestions	___	___	___
Runny Nose	___	___	___
Post-Nasal Drip	___	___	___
Chronic Cough	___	___	___
Dry Throat/Mouth	___	___	___
RESPIRATORY			
Asthma	___	___	___
Chronic Bronchitis	___	___	___
Emphysema	___	___	___
VASCULAR/CARDIOVASCULAR			
Diabetes (A1C#: _____)	___	___	___
Heart Pain	___	___	___
High Blood Pressure	___	___	___
Vascular Disease	___	___	___
GASTROINTESTINAL			
Diarrhea	___	___	___
Constipation	___	___	___
GENITOURINARY			
Genitals	___	___	___
Kidney/Bladder	___	___	___
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	___	___	___
Muscle Pain	___	___	___
Joint Pain	___	___	___
LYMPHATIC/HEMATOLOGIC			
Anemia	___	___	___
Bleeding Problems	___	___	___
PSYCHIATRIC	___	___	___

If you have a condition that's not listed above, please write it below:

_____

_____

Doctor's Signature: _____ Date: _____

Please turn this form over and complete side two