Medical History Questionnaire

Name:_____ Today's Date:_____

Mailing Address:_____ Phone: _____

City:_____ State:_____ Zip:_____ Birth Date:____/____/____

Soc. Sec. #:____/____/____ Occupation/School Grade:_____ Last Eye Exam:____/____/____

Name of Medical Doctor:_____ Last Medical Exam:____/____/____

Medical History

Height:_____Weight:_____

List any ***medications you currently take*** (including prescription, over-the-counter, home remedies, and eye drops):

_____

_____

_____

Do you have ***allergies to any medications?*** ☐No ☐Yes If YES, describe:_____

_____

Please circle ***all major illnesses*** you have had: diabetes / heart disease / high blood pressure / stroke / cancer / arthritis / lupus thyroid / migraines / asthma or emphysema / allergies / kidney disease Other (please list):_____

_____

List any ***major surgeries or injuries*** you have had (with the year if known):_____

_____

List any other medical conditions (such as pregnancy/nursing, etc.) or medical problems that we should know about:

_____

Family History -- note any family history (parents, grandparents, siblings, children), living or deceased, for the following:

DISEASE / CONDITION	YES	NO	?	RELATIONSHIP TO PATIENT
Blindness	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other:_____				_____

Social History

Do you drive? ☐Yes ☐No If YES, do you have any visual difficulty when driving? ☐Yes ☐No

Do you use tobacco products? ☐Yes ☐No If YES, list *type, amount, how long:*_____

Do you drink alcohol? ☐Yes ☐No If YES, list *how much I how often:*_____

****** Please tum this form over and complete side two ******

Eye History Please circle any ***eye conditions*** that you have now or have had in the past:

cataract / glaucoma / macular degeneration / diabetic eye disease/ retinal detachment / "crossed" eyes / lazy eye (amblyopia) / eye infections / color blindness Other (please list):_____

_____

List any ***eye surgeries*** (including Laser) or ***serious eye injuries*** you have had (with the year if known):

_____

_____

Do you currently wear glasses? ☐Yes ☐No If YES, how old are your present glasses?_____

Do you *currently* wear contact lenses? ☐Yes ☐No If NO, have you ever worn contacts? ☐Yes ☐No

If you currently wear contacts, how old are they?_____ __What type are they?_____

Review of Systems Do you ***currently*** have any problems in the following areas?

EYES	**YES**	**NO**
Blurred Vision	☐	☐
Distorted Vision (halos, starbursts, etc.)	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Floaters or Light Flashes	☐	☐
Glare / Light Sensitivity	☐	☐
Tired Eyes	☐	☐
Redness	☐	☐
Dryness	☐	☐
Itching	☐	☐
Burning or Stinging	☐	☐
Sandy or Gritty Feeling	☐	☐
Foreign Body Sensation	☐	☐
Eye Pain or Soreness	☐	☐
Excess Tearing /Watering	☐	☐
Mucous Discharge	☐	☐
ALLERGIC /IMMUNOLOGIC		
Hay Fever	☐	☐
Lupus	☐	☐
CARDIOVASCULAR		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease (blockage, etc.)	☐	☐
EARS, NOSE, MOUTH & THROAT		
Hearing Difficulty / Deafness	☐	☐
Sinus Congestion /Infection	☐	☐
Dry Mouth/Throat	☐	☐

ENDOCRINE	**YES**	**NO**
Diabetes	☐	☐
Thyroid Dysfunction	☐	☐
GASTROINTESTINAL		
Ulcer	☐	☐
Stomach /Intestinal Disease	☐	☐
GENITOURINARY		
Kidney Ailments	☐	☐
Sexually Transmitted Disease (STD)	☐	☐
HEMATOLOGIC (blood) / LYMPHATIC		
Anemia	☐	☐
High Cholesterol	☐	☐
INTEGUMENTARY (skin)		
Rosacea	☐	☐
Skin Cancer	☐	☐
MUSCLES / JOINTS / BONES		
Arthritis	☐	☐
NEUROLOGICAL		
Headaches / Migraines	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy / Seizures	☐	☐
PSYCHIATRIC		
Anxiety Disorder	☐	☐
Depression	☐	☐
RESPIRATORY		
Asthma / Bronchitis / Emphysema	☐	☐
CONSTITUTIONAL		
Fever, Weight Gain/Loss	☐	☐

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

_____

_____

_____

_____

Doctor's Signature:_____ **Date:**_____