Medical History Questionnaire

Patient Name _____ Today's Date _____/_____/_____

Date of Birth _____ Age_____ Spouse or Parent _____

Your Mailing Address _____ City_____ State____ Zip_____

Permanent Address _____ City _____ State____ Zip_____

Last 4 Digits Social Security #_____ Home/Cell Phone _____ Work Phone_____

Occupation of Patient _____ Employer _____

Occupation of Parent or Spouse _____ Employer _____

Name of Closest Relative for Emergencies / City / State_____

Vision Insurance Company_____ ID#_____ Group #_____

Medical/Health Insurance Company_____ ID#_____ Group # _____

Referred to our Office by: _____

Last Vision Examination _____ From Dr. _____

Name of Medical Doctor: _____ Dr's Phone: _____

Last Medical Exam: _____/_____/_____ Do you have any allergies to medications? □ No □ Yes

If yes, explain: _____

Medications Currently Used (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

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

_____

Are you exposed to any occupational hazards? If yes, please explain: _____

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

Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? □ No □ Yes If yes, how old is your present pair of lenses? _____

Contact Lens Type: □ Rigid □ Soft □ Extended Wear □ Toric □ Frequent Replacement/Disposable

Are your contact lenses comfortable? _____

Please turn this form over and complete side two

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
Glaucoma	☐	☐	☐	
Cataract	☐	☐	☐	
Blindness	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other_____	☐	☐	☐	

Social History *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

Tobacco Use: ☐ No ☐ Yes Alcohol: ☐ No ☐ Yes Recreational Drugs: ☐ No ☐ Yes

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

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	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excessive Tearing/Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection, Eye/ 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 Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular / Cardiovascular			
Diabetes	☐	☐	☐
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 answered YES to any of the above or have a condition not listed, please explain below.

Doctor's Signature: _____ Date: _____