Medical History Questionnaire

Name: _____ Today's Date: ____/____/_____

Birth Date: ____/____/_____ Social Security #: ____-____-_____ Last Eye Exam: _____/_____/_____

Name of Medical Doctor: _____ Dr.'s Phone #: (___) ___-_____

Last Medical Exam: ____/____/_____

Medical History

Do you have any allergies to medications? □ yes □ no If yes, 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:

_____

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

Are you pregnant and/or nursing? □ yes □ no

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

Do you wear contacts? □ yes □ no If yes, how old is your present pair of lenses? _____

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other: _____ Are they comfortable? □ yes □ no

Family History ☐ Check here if all No (except as noted)

Please note any family history (***parents, grandparents, siblings, children; living or deceased***) for the following conditions:

Disease/Condition	Yes	No	Relationship to you
Blindness			
Cataracts			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

Please continue your Medical History Questionnaire on the back side.

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? □ yes □ no If yes, do you have visual difficulty when driving? □ yes □ no

If yes, please describe:_____

Do you use tobacco products? □ yes □ no If yes, type/amount/frequency: _____

Do you drink alcohol? □ yes □ no If yes, type/amount/frequency:_____

Do you use illegal drugs? □ yes □ no If yes, type/amount/frequency: _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ Other: _____

Review of Systems

Do you currently, or have you ever had any problems, in the following areas:

☐ **Check here if all No (except as noted)**

System	No	Yes
Constitutional		
Fever, Weight Loss/Gain	□	□
INTEFUMENTARY (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/Gritty Feeling	□	□
Itching	□	□
Burning	□	□
Foreign Body Sensation	□	□
Excess Tearing/Watering	□	□
Glare/Light Sensitivity	□	□
Eye Pair/Soreness	□	□
Chronic Infection of Eye/Lid	□	□
Sties or Chalazion	□	□
Flashes/Floaters in Vision	□	□
Tired Eye	□	□
ENDOCRINE		
Thyroid/Other Glands	□	□

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	□	□
LYMPATHIC/HEMATOLOGIC		
Anemia	□	□
Bleeding Problems	□	□
PSYCHIATRIC	□	□

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

_____

_____

_____

Doctor's Signature:_____ Date:_____