Medical History Questionnaire

Name: _____

Birth Date: ____ /____ /____ (Month / Day / Year) Social Security#: _____ /_____ /_____ Today's Date: _____

Last Eye Doctor: _____ Last Eye Exam: _____ /_____ (Month / Year)

Current Medical Dr.: _____ Last Medical Exam: _____ /_____ (Month / Year)

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: _____

_____

Check any of the following that you have had: ❑ **Reading Difficulty** ❑ **Crossed Eyes** ❑ **Lazy Eye** ❑ **Glaucoma** ❑ **Retinal Disease** ❑ **Cataracts** ❑ **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 glasses? _____

How many pair of glasses do you currently use? _____

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

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ Yes ❑ No

Have you had refractive surgery? ❑ Yes ❑ No

At work: Do you perform fine or close-up work? ❑ Yes ❑ No

Are you outdoors all or part of the time? ❑ Yes ❑ No

Is safety protection a concern at work? ❑ Yes ❑ No

Do you have trouble reading signs when driving at night? ❑ Yes ❑ No

Are you bothered by the glare from: Overhead lighting? ❑ Yes ❑ No

A computer screen? ❑ Yes ❑ No

Oncoming headlights at night? ❑ Yes ❑ No

Are you sensitive in bright sunlight? ❑ Yes ❑ No

What hobbies or recreational sports do you enjoy? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease / Condition	Yes	No	Not Sure	Relationship To You
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Systemic Disease / Condition				
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other _____	❑	❑	❑	

** Please turn this form over * and complete Side 2*

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

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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/how long:

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long:

Do you use recreational drugs? ❑ Yes ❑ No If yes, type/amount/how long:

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑ No, I have not.

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

System	Yes	No	Not Sure
Cancer	❑	❑	❑
Constitutional			
Fever, Weight Loss/Gain	❑	❑	❑
Skin (Integumentary)	❑	❑	❑
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	❑	❑	❑
Sty or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
Endocrine			
Thyroid/Other Glands	❑	❑	❑
Psychiatric	❑	❑	❑

System	Yes	No	Not Sure
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	❑	❑	❑
Brain Injury / Stroke	❑	❑	❑
Gastrointestinal			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
Genitourinary			
Genitals/Kidney/Bladder	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
Allergic/Immunologic	❑	❑	❑

DO NOT WRITE BELOW THIS LINE *(Doctor's Comments)*:

I have reviewed this history with the patient: _____

Doctor's Signature / Date