Medical History Questionnaire

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

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____/_____/_____ Last Eye Exam: _____/_____/_____

How did you hear about us? _____

State of Birth: _____ Cell Phone #: _____ _____ Primary Care Doctor: _____

Gender: _____ Maiden Name: _____

Home Phone No.: _____ Work Phone No.: _____

E-Mail Address: _____ Emergency Phone: _____

Home Address: Street: _____ City: _____ State: _____ Zip: _____

Patient's Employer: _____ Position/Type of Work: _____

Legal Guardian or Spouse: _____ Spouse's Employer: _____

Insurance: Insurance Holder Self ☐ Spouse ☐ Insurance No. _____ Medicaid ☐ Medicare☐
Insurance Holder's Date of Birth: _____

Medical History

Do you have any allergies to medications? No☐ Yes ☐ 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 _____
_____
_____
_____
_____
_____

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	□	□	_____
Retina Detachment/ Disease	□	□	_____
Arthritis	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
Lupus	□	□	_____
Thyroid Disease	□	□	_____
Other _____	□	□	_____

List any of the following that you have had:
Crossed eyes, lazy eye, drooping eye, prominent eyes, retinal disease, eye infections or eye injury:

_____
_____
_____

Are you pregnant or nursing? □ No □ Yes
Do you wear glasses? □ No □ Yes
If yes, how old is your present pair of lenses? _____
Do you wear contacts? □ No □ Yes
If yes, how old is your present pair of lenses?_____
Type of contact lenses? Rigid □ Soft □ Extended Wear □ Other □
Are they comfortable? No □ Yes □

CONTINUE TO BACK

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, explain)

SYSTEM	NO	YES
CONSTITUTIONAL (fever, weight loss/gain)	□	□
INTEGUMENTARY (skin)	□	□
NEUROLOGICAL		
Headaches	□	□
Migraines	□	□
Seizures	□	□
Stroke		
EYES		
Glaucoma	□	□
Cataracts	□	□
Macular Degeneration	□	□
Itching/Burning	□	□
Loss of Vision	□	□
Blurred Vision	□	□
Distorted Vision/Halos	□	□
Double Vision	□	□
Dryness/Excessive Tears/Watery	□	□
Mucous Discharge	□	□
Foreign Body Sensation	□	□
Flashes/Floaters in Vision	□	□
Glare/Light Sensitivity	□	□
Eye Pain or Soreness	□	□
Sandy or Gritty Feeling	□	□
Stye or Chalazion	□	□
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	□	□
Sinus Congestion	□	□
Runny Nose	□	□
Post-Nasal Drip	□	□
Chronic Cough	□	□
Dry Throat/Mouth	□	□

	NO	YES	
RESPIRATORY			
Asthma	□	□	
Chronic Bronchitis	□	□	
Emphysema	□	□	
COPD	□	□	
VASCULAR/CARDIOVASCULAR			
Heart Pain	□	□	
High Blood Pressure		□	□
Vascular Disease	□	□	
High Cholesterol	□	□	
Other _____			
GASTROINTESTINAL			
IBS	□	□	
Crohn's	□	□	
Colitis	□	□	
Gall Bladder Disease	□	□	
Other_____			
GENITOURINARY			
Genitals/kidney/bladder	□	□	
BONES/MUSCLES/JOINTS			
Rheumatoid Arthritis	□	□	
Lupus	□	□	
Other _____			
LYMPHATIC/HEMATOLOGIC			
Anemia	□	□	
Bleeding Problems	□	□	
ENDOCRINE			
Diabetes: Type _____	□	□	
Thyroid	□	□	
ALLERGIC/IMMUNOLOGIC	□	□	
PSYCHIATRIC	□	□	
CANCER: Type_____	□	□	
Date of Diagnosis _____			

Please explain any of the above:

_____

_____

_____

_____

_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.
□ Yes, I prefer to discuss my social history information directly with my doctor.

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

Do you use illegal drugs? □ Yes □ No If yes,
If yes, type/amount/how long: _____

Do you use tobacco products? □ Yes □ No
If yes, type/amount/how long: _____

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

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

Patient's Signature _____