San Tan EyeCare

Medical History Questionnaire

Name:_____ Age: _____ Today's Date:_____
Birth Date: _____ SSN: _____ Last Eye Exam: _____
Address: _____ Last Eye Doctor:_____
City: _____ St: _____ Zip:_____ Last Medical Exam:_____
Phone Number: (h)_____(w) _____ Primary Care Physician: _____
E-mail:_____ _____

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: _____
_____

Are you pregnant and/ or nursing? ❑ Yes ❑ No If yes, explain: _____
Have you had any eye surgeries? ❑ Yes ❑ No If yes, explain: _____
Have you ever had vision therapy? ❑ Yes ❑ No If yes, explain: _____
Have you ever injured your eyes? ❑ Yes ❑ No If yes, explain: _____
Do you wear glasses? ❑ Yes ❑ No If yes, how old are your newest lenses? _____
Do you wear contact lenses? ❑ Yes ❑ No If yes, how old are your newest lenses? _____
Type of contact lenses? ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other _____
Name of lenses: _____ Are they comfortable? _____

Review of Systems

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

Visual System	current	past	never
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Double Vision	❑	❑	❑
Halos	❑	❑	❑
Dryness	❑	❑	❑
Redness	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Excess Tearing	❑	❑	❑
Light Sensitive	❑	❑	❑
Eye Pain	❑	❑	❑
Eye Infections	❑	❑	❑
Floaters	❑	❑	❑
Flashes	❑	❑	❑
Tired Eyes	❑	❑	❑
Crossed Eyes	❑	❑	❑
Cataracts	❑	❑	❑
Glaucoma	❑	❑	❑
Retinal Disease	❑	❑	❑

Systemic System	current	past	never
Diabetes	❑	❑	❑
Heart Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑
Urogenital (kidney, bladder)	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Elevated Cholesterol	❑	❑	❑
Fever	❑	❑	❑
Weight Loss/ Gain	❑	❑	❑
Allergies/ Hay Fever	❑	❑	❑
Gastrointestinal	❑	❑	❑
Thyroid	❑	❑	❑
Neurological (MS, seizures)	❑	❑	❑
Skin (acne, cancer)	❑	❑	❑
Psychiatric (depression, etc.)	❑	❑	❑
Headaches/ Migraines	❑	❑	❑
Respiratory (asthma, bronchitis, etc.)	❑	❑	❑
Other:_____	❑	❑	❑

Please complete back side

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.

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 illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑ None

What type of work do you do? _____

Do you have any hobbies? _____

How many hours per day do you:

Work on a computer? _____

Read? _____

Watch TV? _____

Play video games? _____

Social History

Have any of you 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	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other_____	❑	❑	❑	_____

Our goal is to provide the best, most complete, up-to-date care available. Our philosophy is preventative and developmental in approach. To provide this service in the most efficient manner, please be aware of the following office policies:

- *Fees for services are due at the time those services are rendered.*
- *We reserve the right to charge for missed appointments not canceled in advance.*

Signature: _____ *Date:* _____