MEDICAL HISTORY QUESTIONNAIRE

KELLY VISION CENTER
(615) 868-2877

Patient's Name (first, last):		Birth date: / /	Today's date: / /
Last Eye Doctor (name):	Last Eye Exam (date): / /	Current Weight (lb):	Current Height: _____ ft ______ in

What is your eye problem/complaint today? *Please describe this problem as best as you can*

____

Medications: *List all medications that you currently take (including Over-The-Counter, Vitamins, Supplements, Oral Contraceptives, etc.). Do not worry about filling out this section if you already have a medication list that we can copy. Thank you.*

____

____

____

Any eyedrops or eye medications? ____

Are you allergic to any medications? *If so, please list*: ____

____

Do you want contact lenses or glasses Rx at today's appointment?

☐ Contact Lenses Rx only ☐ Glasses Rx only ☐ BOTH ☐ Neither ☐ I don't know

PERSONAL SOCIAL HISTORY		
Do you wear glasses?	☐ Yes ☐ No	If Yes, how many pairs?:
Do you wear contact lenses?	☐ Yes ☐ No	If Yes, what brand/type?:
Do you drive?	☐ Yes ☐ No	
Are you nursing or pregnant?	☐ Yes ☐ No	
Do you use tobacco products? *(dip, e-cigs, cigarettes)*	☐ Yes ☐ No	If Yes, do you use every day?: ☐ Yes ☐ No If No, have you used in the past?: ☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No	If Yes, what type?:
Do you drink alcohol?	☐ Yes ☐ No	If Yes, how often?:
Have you ever had a blood transfusion?	☐ Yes ☐ No	
Have you ever had an STD?	☐ Yes ☐ No	
Birth order: ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Fifth ☐ >Fifth ☐ Only child ☐ Identical Twin ☐ Fraternal Twin		
How often are you on a computer/TV/Phone a day? ☐ 1-2 Hrs. ☐ 2-4 Hrs. ☐ 4-6 Hrs. ☐ 6-8 Hrs. ☐ >8 Hrs.		

FAMILY OCULAR/MEDICAL HISTORY *Checkmark and fill in all that apply*	**Yes**	**No**	**Relationship to you** *(Brother, Sister, Mother, Father, Grandmother, Grandfather, etc.).* List all that apply.
Blindness			
Glaucoma			
Cataracts			
Retinal disease			
Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
High Blood Pressure / Hypertension			
Other Disease(s) / Prematurity			

PATIENT MEDICAL HISTORY

Check mark for past or present

ALLERGIES (seasonal allergies, food, etc.) ☐ Yes, explain: ____

CARDIOVASCULAR ☐ Stroke ☐ Heart Attack ☐ High Cholesterol ☐ High Blood Pressure
Explain:

CONSTITUTIONAL ☐ Anemia ☐ Fever ☐ Weight Changes ☐ Dizziness ☐ Sleep Problems
Explain:

ENDOCRINE ☐ Diabetes ☐ Gout ☐ Thyroid Disease ☐ Pituitary Complication(s)
Explain:
If Diabetic: ☐ Insulin ☐ Non-Insulin ☐ Last blood sugar level: _____ Date taken: ____ /____ /______

GASTROINTESTINAL ☐ Diarrhea ☐ Pancreatitis ☐ Hepatitis
Explain:

GENITOURINARY ☐ Genital Complication(s) ☐ Kidney Complication(s) ☐ Bladder Complication(s)
Explain:

EAR, NOSE, THROAT ☐ Dryness ☐ Hearing Loss ☐ Dental Complication(s) ☐ Sinus Complication(s)
Explain:

HEMATOLOGIC/LYMPHATIC ☐ Sickle Cell Anemia ☐ Blood Disorder ☐ Breast Cancer
Explain:

IMMUNOLOGIC ☐ Herpes ☐ HIV ☐ Lyme ☐ Sarcoidosis ☐ Tuberculosis
☐ Covid-19 ☐ Cancer (Type:_________ Location:______________)
Explain:

INTEGUMENTARY ☐ Lupus ☐ Skin Disease/Disorder
Explain:

MUSCULOSKELETAL ☐ Arthritis ☐ Joint/Muscle Pain
Explain:

NEUROLOGICAL ☐ Seizures ☐ Dyslexia ☐ Parkinson's ☐ Headaches/Migraines ☐ Multiple Sclerosis
Explain:

PATIENT OCULAR HISTORY

Check mark for past or present. Provide details in the following blanks (date, which eye, ***surgeries****, or other procedures).*

☐ Blindness or Loss of Vision: ____

☐ Glaucoma: ____

☐ Cataracts: ____

☐ Retinal Disease: ____

☐ Macular Degeneration: ____

☐ Eye Injury: ____

☐ Eye Infection: ____

☐ Strabismus (Eye Turn In/Out): ____

☐ Amblyopia (Lazy Eye): ____

☐ Dry Eye: ____

☐ Other Ocular Disease(s): ____

List any other surgeries that you have had:

____

____

____

____

____

SIGNATURE: ____________________________

Date: _____ /______ /_______

**By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor to examine, diagnose, and initiate treatment as deemed appropriate.*