

# Medical History Questionnaire

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Patient's Birthdate \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone \_\_\_\_\_

Work Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cellular Telephone \_\_\_\_\_

Employer \_\_\_\_\_ Email \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

What is your reason for seeking vision care at this time? \_\_\_\_\_

How will today's services/co-pay be paid for: (circle one)

- American Express    
  Check    
  Discover    
  MasterCard    
  Visa    
  Cash

## Review of Systems

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

System	No	Yes	?	No	Yes	?	No	Yes	?		
<b>EYES</b>				<b>CONSTITUTIONAL</b>				<b>VASCULAR/ CARDIOVASCULAR</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEUROLOGICAL</b>				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss Of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ENDOCRINE</b>				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>EARS, NOSE, MOUTH, THROAT</b>				Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES/JOINTS/MUSCLES</b>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERIC/ IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>RESPIRATORY</b>				<b>LYMPHATIC/HEMATOLOGIC</b>			
Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

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

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## 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?  no  yes If yes, do you have visual difficulty when driving? no yes If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  no  yes If yes, type / amount / how long: \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type / amount / how long: \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type / amount / how long: \_\_\_\_\_

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

## Medical History

Do you consider your health?  Good  Fair  Poor

Are you presently taking any medications or drugs?  no  yes If yes, what drugs are you taking?  
(including oral contraceptives, aspirin, over the counter medicines and home remedies) \_\_\_\_\_

Are you allergic to any medications?  no  yes If yes, which? \_\_\_\_\_

Have you ever had major injuries, surgeries and or hospitalizations?  no  yes If yes, list all: \_\_\_\_\_

List any of the following you may 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?  no  yes

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

Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

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

When was your last visit to your physician? \_\_\_\_\_

What is your physician's name? \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_

What is your previous eye doctor's name? \_\_\_\_\_

## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

I hereby authorize the examining doctor to use any diagnostic pharmaceutical agents (eye drops) he may require in the course of this examination.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Doctor's Signature