# Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Phone: _____

_____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Email: _____ Preferred Language: _____

Birth Date: _____ Social Security #: _____ Race/Ethnicity: _____

Gender: _____ Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

## 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: _____

_____

Check any of the following that you have had: ❒ crossed eyes ❒ lazy eye ❒ drooping eyelid ❒ prominent eyes

❒ Glaucoma ❒ retinal disease ❒ cataracts ❒ eye infections ❒ 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 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

**Family History:** 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 | ❒ | ❒ | ❒ | |
| Retinal Detachment or Disease | ❒ | ❒ | ❒ | |
| Arthritis | ❒ | ❒ | ❒ | |

| Disease/Condition | No | Yes | ? | Relationship To You |
|---|---|---|---|---|
| Cancer | ❒ | ❒ | ❒ | |
| Diabetes | ❒ | ❒ | ❒ | |
| Heart Disease | ❒ | ❒ | ❒ | |
| High Blood Pressure | ❒ | ❒ | ❒ | |
| Kidney Disease | ❒ | ❒ | ❒ | |
| Lupus | ❒ | ❒ | ❒ | |
| Thyroid Disease | ❒ | ❒ | ❒ | |
| Other: _____ | | | | |

✳ *Please Turn This Form Over & Complete Side Two* ✳

**Social History**: *This information is kept strictly confidential. 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

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

| System | NO | YES | ? |
|---|---|---|---|
| **Constitutional** | | | |
| Fever, Weight Loss/Gain | ❒ | ❒ | ❒ |
| **Integumentary** (Skin) | ❒ | ❒ | ❒ |
| **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, Eye or Lid | ❒ | ❒ | ❒ |
| Sties or Chalazion | ❒ | ❒ | ❒ |
| Flashes/Floaters in Vision | ❒ | ❒ | ❒ |
| Tired Eyes | ❒ | ❒ | ❒ |
| **Endocrine** | | | |
| Thyroid/Other Glands | ❒ | ❒ | ❒ |

| System | NO | YES | ? |
|---|---|---|---|
| **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 | ❒ | ❒ | ❒ |
| **Gastrointestinal** | | | |
| Diarrhea | ❒ | ❒ | ❒ |
| Constipation | ❒ | ❒ | ❒ |
| **Genitourinary** | | | |
| Genitals/Kidney/Bladder | ❒ | ❒ | ❒ |
| **Bones / Joints / Muscles** | | | |
| Rheumatoid Arthritis | ❒ | ❒ | ❒ |
| Muscle Pain | ❒ | ❒ | ❒ |
| Joint Pain | ❒ | ❒ | ❒ |
| **Lymphatic / Hematologic** | | | |
| Anemia | ❒ | ❒ | ❒ |
| Bleeding Problems | ❒ | ❒ | ❒ |
| **Allergic / Immunologic** | ❒ | ❒ | ❒ |
| **Psychiatric** | ❒ | ❒ | ❒ |

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

_____

_____

_____

_____

_____ _____

Doctor's Signature Date