Medical History Questionnaire

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

Birth Date: ____/____/____ Social Security #: ____-____-____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Last Medical Exam: ____/____/____

Dr.'s Phone #:_____

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:

_____

List any of the following that you 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? □ yes □ no

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

Do you wear contacts? □ yes □ no 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

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	Relationship to you
Blindness			
Cataracts			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

Please continue your Medical History Questionnaire on the back side.

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

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/frequency: _____
Do you drink alcohol? □ yes □ no If yes, type/amount/frequency:_____
Do you use illegal drugs? □ yes □ no If yes, type/amount/frequency: _____
Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ Other: _____

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

	No	Yes
CONSTITUTIONAL		
Fever, Weight Loss/Gain	□	□
INTEFUMENTARY (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/Gritty Feeling	□	□
Itching	□	□
Burning	□	□
Foreign Body Sensation	□	□
Excess Tearing/Watering	□	□
Glare/Light Sensitivity	□	□
Eye Pair/Soreness	□	□
Chronic Infection of Eye/Lid	□	□
Sties or Chalazion	□	□
Flashes/Floaters in Vision	□	□
Tired Eye	□	□
ENDOCRINE		
Thyroid/Other Glands	□	□

	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	□	□
LYMPATHIC/HEMATOLOGIC		
Anemia	□	□
Bleeding Problems	□	□
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:_____