Medical History Questionnaire

Name:____ Today's Date: ______/______/_______

Address: ____ Date of Birth:______/_______/_______

____ Work Phone:______________________

Guardian (if applicable): ________________________________ Cell Phone: _______________________

Email address: ______________________________________ Occupation_______________________

Name of Medical Doctor:__________________________________ Last Eye Exam: ______/______/_______

Who do we thank for referring you today? ____________________________________

REVIEW OF SYSTEMS

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

SYSTEM	No	Yes	Unsure
EYES			
Poor vision	☐	☐	☐
Eye pain	☐	☐	☐
Tearing	☐	☐	☐
Redness	☐	☐	☐
Itching	☐	☐	☐
Jaw Pain	☐	☐	☐
Scalp Tenderness	☐	☐	☐
Spots in vision	☐	☐	☐
Loss of Vision	☐	☐	☐
Constitutional			
Fever	☐	☐	☐
Chills	☐	☐	☐
Weight Loss	☐	☐	☐
ENT and Mouth			
Stuffy Nose	☐	☐	☐
Ear Ache	☐	☐	☐
Cough	☐	☐	☐
Dry Mouth	☐	☐	☐
Cardiovascular			
High Blood Pressure	☐	☐	☐
Rapid Heart Beat	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Congestion	☐	☐	☐
Wheezing	☐	☐	☐
Shortness Of Breath	☐	☐	☐
Gastrointestinal			
Upset Stomach	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Burning on Urination	☐	☐	☐

	No	Yes	Unsure
Urinary Frequency	☐	☐	☐
Incontinence	☐	☐	☐
BONES/JOINTS/MUSCLES			
Joint Pain	☐	☐	☐
Stiffness	☐	☐	☐
Arthritis	☐	☐	☐
Integumentary			
Rash	☐	☐	☐
Changing Moles	☐	☐	☐
Neurological			
Headache	☐	☐	☐
Seizure	☐	☐	☐
Stroke	☐	☐	☐
Paralysis	☐	☐	☐
Psychiatric			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Insomnia	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid Abnormalities	☐	☐	☐
Hematologic / Lymphatic			
Bleeding	☐	☐	☐
Anemia	☐	☐	☐
Allergic/ Immunologic			
Allergies	☐	☐	☐
Hay Fever	☐	☐	☐

**** Please turn this form over and complete side two ****

MEDICAL HISTORY

Do you have any allergies to medication? ☐ No ☐ Yes If yes, explain:________________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter 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? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair?______________________

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair?______________________

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Other Are they comfortable? ☐ No ☐ Yes

Social History

This information is strictly confidential! However, you may discuss this portion with the doctor if you prefer.

☐ *Yes, I would prefer to discuss my social history information directly with the doctor. (Check box)*

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ 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 ☐ None

FAMILY HISTORY

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

DISEASE/CONDITION	No	Yes	Unsure	Relationship to you
Blindness	☐	☐	☐	______________________________
Cataract	☐	☐	☐	______________________________
Crossed Eyes (lazy eye)	☐	☐	☐	______________________________
Glaucoma	☐	☐	☐	______________________________
Macular Degeneration	☐	☐	☐	______________________________
Retinal Detachment	☐	☐	☐	______________________________
Arthritis	☐	☐	☐	______________________________
Cancer	☐	☐	☐	______________________________
Diabetes	☐	☐	☐	______________________________
Heart Disease	☐	☐	☐	______________________________
High Blood Pressure	☐	☐	☐	______________________________
Kidney Disease	☐	☐	☐	______________________________
Lupus	☐	☐	☐	______________________________
Thyroid Disease	☐	☐	☐	______________________________

_***We ask that you kindly turn your cellular phone off while in our office for the benefit of all patients.***