

## Medical History Questionnaire

Today's Date: \_\_\_\_\_ Email: \_\_\_\_\_  
 Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Vision Plan Name: \_\_\_\_\_ ID number: \_\_\_\_\_  
 Medical Plan Name: \_\_\_\_\_ ID number: \_\_\_\_\_  
 Medical Plan phone number (from ID card): \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Name of Insured (spouse/partner/parent): \_\_\_\_\_  
 Last eye exam: \_\_\_\_\_ Doctor's name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Last medical exam: \_\_\_\_\_ Doctor's name: \_\_\_\_\_ Phone#: \_\_\_\_\_

What is your reason for seeking vision care today? \_\_\_\_\_

Are you interested in:  Laser Vision Surgery  Clear/colored contact lenses  Bifocals without lines

### Medical History:

Do you have any allergies to medications?  No  Yes. If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, and over-the-counter medications):

\_\_\_\_\_

\_\_\_\_\_

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 injuries: \_\_\_\_\_

Are you pregnant and/or nursing?  No  Yes  
 Do you wear glasses?  No  Yes  
 Do you wear contact lenses (CLs)?  No  Yes  
 Type of CLs:  Rigid  Soft  Disposable Are they comfortable?  No  Yes

### Family History (relatives living or deceased):

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

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

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

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 conditions in the following areas:

	Yes		Yes
CONSTITUTIONAL		EARS, NOSE, MOUTH, THROAT	
Fever, Weight Loss/Gain	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>
NEUROLOGICAL		Runny Nose	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>
EYES		RESPIRATORY	
Loss of Vision	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR	
Double Vision	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Redness	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	GASTROINTESTINAL	
Itching	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>
Burning	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	GENITO-URINARY	
Excess Tearing/Watering	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	BONES/JOINTS/MUSCLES	
Eye Pain or Soreness	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC	
Tired Eyes	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
ENDOCRINE		Bleeding Problems	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>
		PSYCHIATRIC	<input type="checkbox"/>

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Signature _____	Date _____
Doctor's Signature _____	Date _____