

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 injury: _____

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? Yes No

Family History (relatives living or deceased):

	YES	RELATIONSHIP
Blindness	—	—
Cataract	—	—
Crossed eyes	—	—
Glaucoma	—	—
Macular Degeneration	—	—
Retinal Detachment/Disease	—	—
Arthritis	—	—
Cancer	—	—
Diabetes	—	—
Heart Disease	—	—
High Blood Pressure	—	—
Kidney Disease	—	—
Lupus	—	—
Thyroid Disease	—	—
Other _____	—	—

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	
		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

