Medical History Questionnaire

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

Birth Date: _____ / _____ / _____ Last Medical Exam: _____/_____/_____ Last Eye Exam: _____ / _____ / _____

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

Medical History

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain: _____

_____

_____

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, age of your present lenses. _____

Do you wear contact lenses? ❑ no ❑ yes If yes, age of your present lenses. _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other

Are they comfortable? ❑ yes ❑ no

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

_____ _____

_____ _____

_____ _____

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_____ _____

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid disease	❑	❑	❑	
Other _____	❑	❑	❑	

Social History

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 ❑ Syphilis ❑ HIV ❑ Hepatitis ❑ None

Please turn this form over and complete side two

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

SYSTEM	NO	YES	?	EXPLAIN / LIST MEDICATIONS
CONSTITUTIONAL (fever & weight loss/gain)	❑	❑	❑	
INTEGUMENTARY (Skin)	❑	❑	❑	
NEUROLOGIC				
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 of Eye or Lid	❑	❑	❑	
Sties or Chalazion	❑	❑	❑	
Flashes/Floaters in Vision	❑	❑	❑	
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				
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	❑	❑	❑	
ENDOCRINE(thyroid/other glands)	❑	❑	❑	
ALLERGIC/IMMMUNOLOGICAL	❑	❑	❑	
PSYCHIATRIC	❑	❑	❑	

Doctor's Signature

Review Date