Medical History Questionaire

Welcome to our office! Thank you for choosing our office for your eye care services. Please take the time to complete this questionnaire accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Today's Date: _____

Preferred Salutation: Dr. Mr. Mrs. Ms. Miss. Other : _____

_____ _____ _____ _____

(First Name) (Middle Name) (Last Name) (Maiden Name)

Guardian(if Applicable): _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Last Eye Exam: _____

Family Doctor: _____ Last Medical Exam:_____

Date of Birth: _____ Social Security # _____/_____/_____

Medical History

Do you have any allergies to medications? ___ Yes ___ No

If yes, explain _____

_____

List any medications **you** are currently taking (including contraceptives, aspirin, over the counter medications and home remedies) :

_____

_____

_____

List all major injuries, surgeries and hospitalizations you have had and any current health conditions including those for which **you** are being treated:

_____

_____

_____

List any of the following that you have had:

__ Crossed eyes ___ Lasy Eyes ___ Drooping eyes ____ Prominent eyes

__ Glaucoma ___ Retinal Disease ___ Cataracts ___ Eye Infections

__ Eye injury: _____

☐ You are pregnant and / or nursing

☐ You wear Glasses how old are your glasses prescription _____

☐ You wear Contact lens how old are your Contacts prescription _____

Type of Contact lens ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? _____

Family History

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

Diseases / Condition	Yes	No	?	Relationship to You
Blindness	☐	☐	☐	
Cataracts	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachement / Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
High Blood Preasure	☐	☐	☐	
Hearth Disease	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other:_____	☐	☐	☐	

Social History

This information is kept 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 my doctor.*

Do you drive? Yes ____ No ____

If Yes , do you have difficulty when driving? ___Yes ___ No

If Yes, Describe: _____

Do you use tobaco products? Yes ____ No ____ If Yes, type /amount / how long?: _____

Do you drink alcohol? Yes ____ No ____ If Yes, type /amount / how long?: _____

Do you use illegal drugs? Yes ____ No ____ 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 problems in the following areas:

System	Yes	No	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary (skin)	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Macous Discharges	☐	☐	☐
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 Lids	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid / Other Glands	☐	☐	☐

System	Yes	No	?
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	☐	☐	☐
Hearth Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarhiea	☐	☐	☐
Constipation	☐	☐	☐
Genitournary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthitis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic / Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic / Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered YES to any of the above or have a condition not list, Please explain & list medications:

_____

_____

_____