Medical History Questionnaire



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| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ |
| Birth Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last Eye Exam: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ |
| Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Dr.’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Last Medical Exam: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ |  |  |

Medical History:

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

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

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| --- | --- | --- | --- | --- |
| Are you pregnant and/or nursing? | ☐ No | ☐ Yes |  |  |
| Do you wear glasses? |  | ☐ No | ☐ Yes | If yes, how old is your present pair of lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you wear contact lenses? | ☐ No | ☐ Yes | If yes, how old is your present pair of lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Type of contact lenses? | ☐ Rigid | ☐ Soft ☐ Extended Wear ☐ Other | Are they comfortable? ☐ Yes ☐ No |

Family History:

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following 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: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer ☐ Yes, I would prefer to discuss my Social History information directly with my doctor (check box)

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 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 an problems in the following areas: |  |  |  |
|  | NO | YES | ? |  | NO | YES | ? |
| CONSTITUTIONAL |  |  |  | EARS, NOSE, MOUTH, THROAT |  |  |  |
| Fever, Weight Loss / Gain | ☐ | ☐ | ☐ | Allergies / Hay Fever | ☐ | ☐ | ☐ |
| INTEGUMENTARY (Skin) | ☐ | ☐ | ☐ | Sinus Congestion | ☐ | ☐ | ☐ |
| NEUROLOGICAL |  |  |  | Runny Nose | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ | Post-Nasal Drip | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ | Chronic Cough | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | Dry Throat/Mouth | ☐ | ☐ | ☐ |
| EYES |  |  |  | RESPIRATORY |  |  |  |
| Loss of Vision | ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ | ☐ |
| Distorted Vision/Halos | ☐ | ☐ | ☐ | Emphysema | ☐ | ☐ | ☐ |
| Loss of Side Vision | ☐ | ☐ | ☐ | VASCULAR DISEASE | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ | Heart Pain | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ | GASTROINTESTINAL | ☐ | ☐ | ☐ |
| Sandy or Gritty Feeling | ☐ | ☐ | ☐ | Diarrhea | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ | Constipation | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ | GENI / URINARY | ☐ | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ | ☐ | Genitals / Kidney / Bladder | ☐ | ☐ | ☐ |
| Excess Tearing / Watering | ☐ | ☐ | ☐ | BONES / JOINTS / MUSCLES | ☐ | ☐ | ☐ |
| Glare / Light Sensitivity | ☐ | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ | Muscle Pain | ☐ | ☐ | ☐ |
| Chronic Infection of Eye or Lid | ☐ | ☐ | ☐ | Joint Pain | ☐ | ☐ | ☐ |
| Sties or Chalazion | ☐ | ☐ | ☐ | LYMPHATIC / HEMATOLOGIC | ☐ | ☐ | ☐ |
| Flashes / Floaters in Vision | ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ | Bleeding Problems | ☐ | ☐ | ☐ |
| ENDOCRINE |  |  |  | ALLERGIC / IMMUNOLOGIC | ☐ | ☐ | ☐ |
| Thyroid / Other Glands | ☐ | ☐ | ☐ | PSYCHIATRIC | ☐ | ☐ | ☐ |

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

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Signature Date