



## MEDICAL HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City, Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
Guardian \_\_\_\_\_ Occupation \_\_\_\_\_  
Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_  
Name of Medical Doctor \_\_\_\_\_ Last Eye Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Doctor's Phone \_\_\_\_\_ Last Medical Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Medical History

Do you have any allergies to medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

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

Are you pregnant and/or nursing? \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ If yes, how old is your present pair? \_\_\_\_\_

Do you wear contacts? \_\_\_\_\_ If yes, how old is your present pair? \_\_\_\_\_

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:

<i>Disease/Condition</i>	<i>No/Yes</i>	<i>Relationship to You</i>
Blindness	_____	_____
Cataract	_____	_____
Crossed Eye	_____	_____
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 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 problems in the following areas?

<b>System</b>	<b>No/Yes</b>	<b>System</b>	<b>No/Yes</b>
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	_____
Distorted Vision/Halos	_____	Chronic Bronchitis	_____
Loss of Side Vision	_____	Vascular/Cardiovascular	_____
Double Vision	_____	Diabetes	_____
Dryness	_____	Heart Pain	_____
Mucous Discharge	_____	High Blood Pressure	_____
Redness	_____	Vascular Disease	_____
Sandy or Gritty Feeling	_____	Gastrointestinal	_____
Itching	_____	Diarrhea	_____
Burning	_____	Constipation	_____
Foreign Body Substance	_____	Genitourinary	_____
Excess Tearing/Watering	_____	Genitals/Kidney/Bladder	_____
Glare/Light Sensitivity	_____	Bones/Joints/Muscles	_____
Eye Pain or Soreness	_____	Rheumatoid Arthritis	_____
Chronic Infection of Eye/Lid	_____	Muscle Pain	_____
Sties or Chalazion	_____	Joint Pain	_____
Flashes/Floaters	_____	Lymphatic/Hematological	_____
Tired Eyes	_____	Anemia	_____
Endocrine	_____	Bleeding Problems	_____
Thyroid/Other Glands	_____	Allergic/Immunologic	_____
		Psychiatric	_____

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

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