

# MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Guardian(if applicable) \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_  
Name of Medical Doctor: \_\_\_\_\_ Dr's Phone: \_\_\_\_\_  
E-mail address \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_  
Do you have Vision Insurance?  No  Yes If yes, carrier \_\_\_\_\_ Occupation: \_\_\_\_\_  
Do you have Medical Insurance?  No  Yes If yes, carrier \_\_\_\_\_  
If this is your first visit, how did you hear about us?  Insurance  Internet  Flyer  Friend \_\_\_\_\_

## MEDICAL HISTORY

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

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and herbal supplements):  
\_\_\_\_\_  
\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_  
\_\_\_\_\_

Check 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, explain: \_\_\_\_\_

Are you pregnant and/or nursing?  Yes  No If yes, how many weeks pregnant or nursing \_\_\_\_\_

Do you wear glasses?  Yes  No If yes, how old is your present pair of lenses? \_\_\_\_\_

Are you interested in contact lenses?  Yes  No Do you sleep in your contact lenses? \_\_\_\_\_

Do you wear contact lenses?  Yes  No 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:

### DISEASE/CONDITION

Blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Cataract	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Crossed Eyes/Eyeturn	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Macular Degeneration	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Retinal Detachment/Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Lupus	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?
Other	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> ?

### RELATIONSHIP TO YOU

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

-OVER-

**SOCIAL HISTORY**

This information is kept strictly 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 (Check box)

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  Tuberculosis  N/A

**HEALTH HISTORY/REVIEW OF SYSTEMS**

Do you currently, or have you ever had any problems in the following areas:

**CARDIOVASCULAR/VASCULAR**

Heart Trouble/Pain  No  Yes  ?

High Blood Pressure  No  Yes  ?

Vascular Disease  No  Yes  ?

**CONSTITUTIONAL**

Fever  No  Yes  ?

Weight Loss/Gain  No  Yes  ?

**EARS, NOSE, MOUTH, THROAT**

Allergies/Hay Fever  No  Yes  ?

Chronic Cough  No  Yes  ?

Dry Throat/Mouth  No  Yes  ?

Ear Infection  No  Yes  ?

Sinus Congestion  No  Yes  ?

**ENDOCRINE**

Diabetes  No  Yes  ?

Thyroid/other glands  No  Yes  ?

**EYES**

Blurred Vision  No  Yes  ?

Burning  No  Yes  ?

Distorted Vision/Halos  No  Yes  ?

Double Vision  No  Yes  ?

Dryness  No  Yes  ?

Excess Tearing/Watering  No  Yes  ?

Eye Pain or Soreness  No  Yes  ?

Flashes/Floaters in Vision  No  Yes  ?

Foreign Body Sensation  No  Yes  ?

Glare/Light Sensitivity  No  Yes  ?

Glaucoma  No  Yes  ?

Infection of Eye or Lid  No  Yes  ?

Itching  No  Yes  ?

Loss of Side Vision  No  Yes  ?

Loss of Vision  No  Yes  ?

Mucous Discharge  No  Yes  ?

**EYES**

Redness  No  Yes  ?

Retinal Tear/Detachment  No  Yes  ?

Sandy or Gritty Feeling  No  Yes  ?

Styes or Chalazion  No  Yes  ?

Tired Eyes  No  Yes  ?

**GASTROINTESTINAL**

Constipation  No  Yes  ?

Diarrhea  No  Yes  ?

**GENITOURINARY**

Bladder  No  Yes  ?

Kidney  No  Yes  ?

**HEMATOLOGIC/LYMPHATIC**

Anemia  No  Yes  ?

Bleeding Problems  No  Yes  ?

Hepatitis  No  Yes  ?

**IMMUNOLOGIC**

AIDS/HIV  No  Yes  ?

Syphilis  No  Yes  ?

**INTEGUMENTARY (Skin)**  No  Yes  ?

**MUSCULOSKELETAL**

Arthritis/Rheumatoid  No  Yes  ?

Joint Pain  No  Yes  ?

Muscle Pain  No  Yes  ?

**NEUROLOGICAL**

Headaches  No  Yes  ?

Migraines  No  Yes  ?

Seizures  No  Yes  ?

**PSYCHIATRIC**

**RESPIRATORY**

Asthma  No  Yes  ?

Chronic Bronchitis  No  Yes  ?

Emphysema  No  Yes  ?

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

I have reviewed my medical history dated \_\_\_\_\_ and there are no changes. Initial: \_\_\_\_\_ Doctor: \_\_\_\_\_