# Medical History Questionnaire

Name: _____ Today's Date: _____
Address: _____ Home Phone: _____
City: _____ Zip code: _____ Work Phone: _____
Birth Date: _____
Name of Vision Plan: _____ Occupation _____
Name of Medical Plan: _____ Insur phone # (on ID card) _____
Name of Insured (spouse/partner): _____
Last Eye exam: _____ Doctor's name: _____ Phone#: _____
Last Medical exam: _____ Doctor's name: _____ Phone#: _____

What is your reason for seeking vision care today? _____

Are you interested in _Laser Vision Surgery _Clear/colored contact lenses _Bifocals without lines

**Medical History:**
Do you have any allergies to medications? _No _Yes. If yes, explain: _____

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

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
Do you wear contact lenses (CLs)? _No _Yes
Type of CLs: _Rigid _Soft _Disposable Are they comfortable? _Yes _No

**Family History** (relatives living or deceased):

| | YES | RELATIONSHIP |
|---|---|---|
| Blindness | _ | _ |
| Cataract | _ | _ |
| Crossed eyes | _ | _ |
| Glaucoma | _ | _ |
| Macular Degeneration | _ | _ |
| Retinal Detachment/Disease | _ | _ |
| Arthritis | _ | _ |
| Cancer | _ | _ |
| Diabetes | _ | _ |
| Heart Disease | _ | _ |
| High Blood Pressure | _ | _ |
| Kidney Disease | _ | _ |
| Lupus | _ | _ |
| Thyroid Disease | _ | _ |
| Other_____ | _ | _ |

*Please turn this form over and complete side two*

E-mail Address _____

**Social History** *This information is kept strictly confidential. However, you may discuss this portion directly 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 conditions in the following areas:

| | YES | | 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/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 Sensation | _ | GENITO-URINARY | |
| Excess Tearing/Watering | _ | Genitals/Kidney/Bladder | _ |
| Glare/Light Sensitivity | _ | BONES/JOINTS/MUSCLES | |
| Eye Pain or Soreness | _ | Rheumatoid Arthritis | _ |
| Chronic Infection of Eye or Lid | _ | Muscle Pain | _ |
| Sties or Chalazion | _ | Joint Pain | _ |
| Flashes/Floaters in Vision | _ | LYMPHATIC/HEMATOLOGIC | |
| 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 medications: _____

_____

_____

_____

_____ _____

Doctor's Signature Date