Medical History Questionaire

Name _____ Today's Date / /

Social Security Number / / Date of Birth #7C / / Height Ft In Weight #8C Lbs

When was your last eye exam? / / Are you planning to update your glasses today? ☐ Yes ☐ No ☐ Undecided

Name of Medical Doctor _____ Dr's Phone _____ Last Medical Exam / /

Medical History

Do you have any allergies to medications? #6C ☐ No ☐ Yes If yes, explain: _____

List any eye medications you take: #5C _____

List any other medications you take (incl. oral contraceptives, aspirin, over the counter medications & home remedies): #5C _____

List all major injuries, surgeries, and/or hospitalizations: _____

List any of the following that you have experienced: 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 If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your current pair of lenses? _____

Do you wear 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:

				RELATIONSHIP TO YOU:						
DISEASE / CONDITION	NO	YES	?	Mother	Father	Sister	Brother	Son	Daughter	Other:
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? ☐ No ☐ Yes If yes, please describe:

Have you ever used tobacco? #9C ☐ No ☐ Yes If yes, ☐ Former ☐ Current Every Day ☐ Current Some Days ☐ Current Smokeless Tobacco User

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 [inc]

Do you currently, or have you ever had any problems in the following areas? (If yes, please explain and list medications).

SYSTEM	NO	YES	?	EXPLAIN / LIST MEDICATIONS
CONSTITUTIONAL (fever, weight loss / gain)	☐	☐	☐	
INTEGUMENTARY (skin)	☐	☐	☐	
NEUROLOGICAL				
Headaches	☐	☐	☐	
Migraines	☐	☐	☐	
Seizures	☐	☐	☐	
EYES				
Loss of Vision	☐	☐	☐	
Blurred Vision	☐	☐	☐	
Distorted Vision / Halos	☐	☐	☐	
Loss of Side Vision	☐	☐	☐	
Double Vision	☐	☐	☐	
Dryness	☐	☐	☐	
Mucous Discharge	☐	☐	☐	
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 Lid	☐	☐	☐	
Sties or Chalazon	☐	☐	☐	
Flashes / Floaters in Vision	☐	☐	☐	
Tired Eyes	☐	☐	☐	
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	☐	☐	☐	
Heart Pain	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Vascular Disease	☐	☐	☐	
GASTROINTESTINAL				
Diarrhea	☐	☐	☐	
Constipation	☐	☐	☐	
GENITOURINARY (genitals / kidney / bladder)	☐	☐	☐	
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis	☐	☐	☐	
Muscle Pain	☐	☐	☐	
Joint Pain	☐	☐	☐	
LYMPHATIC / HEMATOLOGIC				
Anemia	☐	☐	☐	
Bleeding Problems	☐	☐	☐	
ENDOCRINE (thyroid, other glands)	☐	☐	☐	
ALLERGIC / IMMUNOLOGIC	☐	☐	☐	
PSYCHIATRIC	☐	☐	☐	

Doctor's Signature

Date