TODAY'S DATE _____ / _____ / _____

Medical History Questionnaire

Name: _____ Home Phone: _____ Preferred Method of Contact: ☐

Address : _____ Cell Phone: _____ Text OK ☐ ☐

City: _____ Zip: _____ Work Phone: _____ ☐

Occupation: _____ Employer: _____ E-Mail: _____ ☐

Birth Date: _____ / _____ / _____ Social Security #: _____-_____-_____ Last Eye Exam: _____ / _____ / _____

DEMOGRAPHICS

If Minor, Parent/Guardian name: _____ SSN: _____ DOB: _____ Employer: _____

Vision Insurance Carrier: _____ Subscriber Name: _____ Contact #: _____

Medical Insurance Carrier: _____ Subscriber Name: _____ Contact #: _____

How did you hear about us? Family or friend? _____ Yellow Pages? _____ Other? _____

MEDICAL HISTORY

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain: _____

List all medications (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, refractive surgery: _____

Vitals: Height: _____ ***Weight:*** _____

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? ❑ no ❑ yes

Are you interested in contact lenses? ❑ no ❑ yes Are you interested in refractive / LASIK surgery? ❑ no ❑ yes

FAMILY HISTORY - please note any family history (parents, grandparents, siblings, living or deceased)

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
BLINDNESS	❑	❑	❑	
CATARACT	❑	❑	❑	
CROSSED EYE	❑	❑	❑	
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

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 Y 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, 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:

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYE			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy of Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

	NO	YES	?
EAR, 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			
High Blood Pressure	❑	❑	❑
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Cholesterol	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC/HEMATOLOGIC			
Anemia	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

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

_____

_____

_____

PATIENT SIGNATURE _____

_____ _____

DOCTOR'S SIGNATURE DATE