

Medical History Questionnaire

General Information

Title (circle): Mr. / Mrs. / Ms. / Dr. / Pronoun(s) _____ Today's date: ____/____/____
 First name: _____ MI: ____ Last name: _____ Date of Birth: ____/____/____
 Address: _____ Social Security #: ____/____/____
 City: _____ State: _____ Zip: _____ Best phone number: _____
 Email address: _____ (circle: home, work, or cell)
 Guardian (if applicable): _____ Relationship: _____ Work phone: _____
 Occupation: _____
 If using insurance: Insurance primary cardholder info (name, DOB, SSN): _____
 Do you give us permission to email and/or text you notifications? Preference (circle): email / text / both

Medical History

Do you have any allergies to medications? no yes
 If yes, what are you allergic to and what is your reaction?

Last eye exam: ____/____/____
 Last medical exam: ____/____/____
 Name of PCP: _____
 PCP's phone: _____
 PCP's fax: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, 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 injuries: _____

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: 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 | NO | YES | ? | RELATIONSHIP TO YOU |
|----------------------------|--------------------------|--------------------------|--------------------------|---------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

* 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 my Social History information directly with my doctor (check box)

Do you drive? no yes

If yes, please describe any visual difficulties you may have when driving: _____

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 (check all that apply):

Gonorrhea Hepatitis HIV Syphilis None of the above

Review of Systems

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

| System | NO | YES | ? | System | NO | YES | ? |
|---------------------------------|--------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--------------------------|
| CONSTITUTIONAL | | | | EARS, NOSE, MOUTH, THROAT | | | |
| Fever, Sudden Weight Loss/Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies/Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| INTEGUMENTARY (Skin) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NEUROLOGICAL | | | | Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Post-Nasal Drip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry Throat/Mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EYES | | | | RESPIRATORY | | | |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Distorted Vision/Halos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Side Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VASCULAR / CARDIOVASCULAR | | | |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mucous Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sandy or Gritty Feeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | GASTROINTESTINAL | | | |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign Body Sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | GENITOURINARY | | | |
| Excess Tearing/Watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Genitals/Kidney/Bladder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glare/Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | BONES / JOINTS / MUSCLES | | | |
| Eye Pain or Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sties or Chalazion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flashes/Floaters in Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LYMPHATIC / HEMATOLOGIC | | | |
| Tired Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ENDOCRINE | | | | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid/Other Glands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PSYCHIATRIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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