

# Medical History Questionnaire

Mr. Mrs. Miss Ms. (circle one) Other \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_  
Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_ Zip Code \_\_\_\_\_ Email: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Occupation: \_\_\_\_\_

Social Security #: \_\_\_/\_\_\_/\_\_\_ Last Eye Exam: \_\_\_/\_\_\_/\_\_\_  
Last Medical Exam: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Group#: \_\_\_\_\_  
Member # or I.D.: \_\_\_\_\_  
Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_  
What is the reason for your visit today? \_\_\_\_\_

## Medical History

Do you have any allergies to medications?  no  yes If yes, please list \_\_\_\_\_

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

List any medical conditions: \_\_\_\_\_

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataract, eye infections or eye injury.

Are you pregnant and / or nursing?  no  yes

Do you have children?  no  yes Their ages are? \_\_\_\_\_

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

How much time do you spend at a computer? \_\_\_\_\_

## Social History

*This information is 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: \_\_\_\_\_

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

SYSTEM	NO	YES	?
<b>Constitutional</b>			
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>			
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness/Sandy/Gritty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching / Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain/Soreness/Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>			
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergic / Immunologic</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Psychiatric</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

problems in the following areas:

SYSTEM	NO	YES	?
<b>Ears, Nose, Mouth, Throat</b>			
Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose /Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular / Cardiovascular</b>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitourinary</b>			
Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bones / Joints / Muscles</b>			
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle / Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lymphatic / Hematologic</b>			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease / Condition	YES	Relationship	Disease / Condition	YES	Relationship
Blindness	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	_____
Cross Eyes	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____			