# Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Phone/ Work Phone: _____

City: _____ State _____ Zip _____ E-mail: _____

Birth Date: ____/____/____ Social Security #: ____/____/____ Last Eye Exam: ____/____/____

Ethnicity _____ (optional)

**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 any 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 infection or eye injury: _____

_____

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 Are they comfortable? ❑ yes ❑ no

Are you planning to get new glasses today? ❑ yes ❑ no ❑ only if prescription changes

Are you planning to get new contacts today? ❑ yes ❑ no ❑ only if prescription changes

Are you interested in finding out more about laser vision correction? ❑ yes ❑ no

**ht: wt: bp:**

**Family History**

Please note any family history (parents, grandparents, siblings, etc.) for the following conditions:

| DISEASE/CONDITION | NO | YES | RELATIONSHIP TO YOU |
|---|---|---|---|
| Blindness | ❑ | ❑ | _____ |
| Cataract | ❑ | ❑ | _____ |
| Crossed Eyes | ❑ | ❑ | _____ |
| Glaucoma | ❑ | ❑ | _____ |
| Macular Degeneration | ❑ | ❑ | _____ |
| Retinal Detachment/Disease | ❑ | ❑ | _____ |
| Arthritis | ❑ | ❑ | _____ |
| Cancer | ❑ | ❑ | _____ |
| Diabetes | ❑ | ❑ | _____ |
| High Blood Pressure | ❑ | ❑ | _____ |
| Other | ❑ | ❑ | _____ |

***Please turn this form over and complete side two****

**Social History**

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes

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? _____

**Review of Systems**

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

| System | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Constitutional | | | Ears, Nose, Mouth, Throat | | |
| Fever, Weight Loss / Gain | ❑ | ❑ | Allergies / Hay Fever | ❑ | ❑ |
| Integumentary | ❑ | ❑ | Sinus Congestion | ❑ | ❑ |
| Neurological | | | Runny Nose | ❑ | ❑ |
| Headaches | ❑ | ❑ | Chronic Cough | ❑ | ❑ |
| Migraines | ❑ | ❑ | Dry Throat / Mouth | ❑ | ❑ |
| Seizures | ❑ | ❑ | Respiratory | | |
| Eyes | | | Asthma | ❑ | ❑ |
| Loss of Vision | ❑ | ❑ | Chronic Bronchitis | ❑ | ❑ |
| Blurred Vision | ❑ | ❑ | Emphysema | ❑ | ❑ |
| Distorted Vision / Halos | ❑ | ❑ | Vascular / Cardiovascular | | |
| Loss of Side Vision | ❑ | ❑ | Diabetes | ❑ | ❑ |
| Double Vision | ❑ | ❑ | Heart Pain | ❑ | ❑ |
| Dryness | ❑ | ❑ | High Blood Pressure | ❑ | ❑ |
| Mucous Discharge | ❑ | ❑ | Vascular Disease | ❑ | ❑ |
| Redness | ❑ | ❑ | Gastrointestinal | | |
| Gritty Feeling | ❑ | ❑ | Diarrhea | ❑ | ❑ |
| Itching | ❑ | ❑ | Constipation | ❑ | ❑ |
| Burning | ❑ | ❑ | Genitourinary | | |
| Foreign Body Sensation | ❑ | ❑ | Kidneys / Bladder | ❑ | ❑ |
| Excess Tearing / Watering | ❑ | ❑ | Bones / Joints / Muscles | | |
| Glare / Light Sensitivity | ❑ | ❑ | Rheumatoid Arthritis | ❑ | ❑ |
| Eye Pain or Soreness | ❑ | ❑ | Muscle Pain | ❑ | ❑ |
| Infection of Eye or Lid | ❑ | ❑ | Joint Pain | ❑ | ❑ |
| Sties or Chalazion | ❑ | ❑ | Lymphatic / Hematologic | | |
| Flashes / Floaters in Vision | ❑ | ❑ | Anemia | ❑ | ❑ |
| Tired Eyes | ❑ | ❑ | Bleeding Problems | ❑ | ❑ |
| Endocrine | | | Allergic / Immunologic | ❑ | ❑ |
| Thyroid / Other Glands | ❑ | ❑ | Psychiatric | ❑ | ❑ |

If you answered yes to any of the above or have a condition not listed, please explain:

_____

_____

_____

_____ _____

Doctor's signature Date