Medical History Questionnaire

Name _____ Today's Date ____/____/____

Address _____ City _____ ST ____ Zip _____

Phone Numbers: (__)_____ Home/Evening (__)_____ Daytime (__)_____ Other | Birthdate: ____/____/____

Name of Insurance _____ Policy # _____ SSN___ - ___ - _____ Age _____

Parent/Spouses Name _____

Name of your physician referring you _____ Physician Phone _____

Physician Address _____ Date of last medical exam ___/___/____

Whom may we thank for your referral? _____

E-Mail Address: _____ Date of last eye exam ___/___/____

MEDICAL AND PAST HISTORY

List any medications you take: _____ _____ _____

_____ _____ _____

List all major illnesses and injuries _____ _____ _____

_____ _____ _____

List any surgeries you have had _____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had crossed eyes? ☐ Yes ☐ No _____

Have you had lazy eye? ☐ Yes ☐ No _____

Have you had drooping eyelid? ☐ Yes ☐ No _____

Have you had prominent eyes? ☐ Yes ☐ No _____

Do you have allergies to any medications ☐ Yes ☐ No _____

If YES, please list: _____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness	☐	☐	
Cataract	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart attacks	☐	☐	
High blood pressure	☐	☐	
Kidney disease	☐	☐	
Lupus	☐	☐	
Sjogren's Syndrome	☐	☐	
Stroke	☐	☐	
Thyroid disease	☐	☐	
Tuberculosis	☐	☐	
Other	☐	☐	

SOCIAL HISTORY *(This information is kept strictly confidential. However, you may discuss this portion only with the doctor if you prefer.)*

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Current occupation: _____

Do you drive? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Have you ever tried to wear contacts? ☐ Yes ☐ No _____

Do you currently wear contact? ☐ Yes ☐ No If Yes, brand and replacement schedule _____

*Please turn this form over and complete side 2**

(SOCIAL HISTORY CONTINUED)

Do you currently wear glasses? ☐ Yes ☐ No

If YES, how long have you had your current pair? _____

Do you drink alcohol? ☐ Yes ☐ No

If YES, how many glasses a day? _____

Do you smoke? ☐ Yes ☐ No

If YES, how many packs a day? _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever been exposed to HIV or other sexually transmitted disease? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes", provide information.

	YES	NO
Constitutional Symptoms		
Fever	☐	☐
Weight loss	☐	☐
Other	☐	☐
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	☐	☐
Occasional tearing	☐	☐
Glare/Light sensitivity	☐	☐
Eye pain or soreness	☐	☐
Chronic infection of eye or lid	☐	☐
Sties, Chalazion	☐	☐
Fluctuating visual acuity	☐	☐
Tired eyes	☐	☐
Psychiatric	☐	☐
Endocrine	☐	☐
Thyroid and other glands	☐	☐
Hematologic/Lymphatic		
Blood	☐	☐
Lymph nodes	☐	☐
Swelling	☐	☐

	YES	NO
Ears, nose, mouth, throat		
Sinus congestion	☐	☐
Runny nose	☐	☐
Postnasal drip	☐	☐
Chronic cough	☐	☐
Dry throat/mouth	☐	☐
Vascular/ Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Respiratory (lungs/breathing)	☐	☐
Chronic bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Gastrointestinal (stomach/intestines)	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary (genitals/kidney/bladder)	☐	☐
Musculoskeletal		
Muscle pain	☐	☐
Joint pain	☐	☐
Rheumatoid Arthritis	☐	☐
Integumentary (skin and/or breast)	☐	☐
Neurological	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Allergic/Immunologic	☐	☐
Head allergy symptoms	☐	☐
Seasonal allergies	☐	☐
Hay fever symptoms	☐	☐

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

_____

_____

_____

Are you interested in Laser Vision Correction _____ or Contact Lenses _____ ?

History reviewed. ☐ No changes ☐ Additions as noted above

Physician's signature: _____ Date: _____