

### Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical History**

Do you have any allergies to medications? \_\_\_\_no \_\_\_\_yes If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any medications you take (including eye drops, 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 eyelids, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had any eye surgery (including laser) Give Dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you pregnant and/or nursing? \_\_\_\_no \_\_\_\_yes  
 Do you currently 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 Brand \_\_\_\_\_  
 Are your contact lenses comfortable? \_\_\_\_no \_\_\_\_yes

**Family History**

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

<b>DISEASE/CONDITION</b>	<b>YES</b>	<b>NO</b>	<b>RELATIONSHIP TO YOU</b>
Blindness	____	____	_____
Cataracts	____	____	_____
Crossed Eyes	____	____	_____
Glaucoma	____	____	_____
Macular Degeneration	____	____	_____
Retinal Detachment/Disease	____	____	_____
Arthritis	____	____	_____
Cancer	____	____	_____
Diabetes	____	____	_____
Heart Disease	____	____	_____
High Blood Pressure	____	____	_____
Kidney Disease	____	____	_____
Lupus	____	____	_____
Thyroid Disease	____	____	_____
Other: _____	____	____	_____

**Review of Symptoms**

Do you currently or have you ever had any problems in the following areas? If you answer YES to any of the following or have a condition not listed, please explain in the margin to the right of the yes and no boxes.

<b>SYMPTOMS</b>	<b>YES</b>	<b>NO</b>	<b>SYMPTOMS</b>	<b>YES</b>	<b>NO</b>
<b>EYES</b>			<b>RESPIRATORY</b>		
Loss of Vision	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Blurred Vision	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>
Distorted Vision/Halos	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>
Loss of Side Vision	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
Double Vision	<input type="radio"/>	<input type="radio"/>	<b>VASCULAR/CARDIOVASCULAR</b>		
Dryness	<input type="radio"/>	<input type="radio"/>	Chest Pain	<input type="radio"/>	<input type="radio"/>
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	Vascular Disease	<input type="radio"/>	<input type="radio"/>
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>
Itching	<input type="radio"/>	<input type="radio"/>	Atrial Fibrillation, Irregular Heart Beat	<input type="radio"/>	<input type="radio"/>
Burning	<input type="radio"/>	<input type="radio"/>	Coronary Bypass	<input type="radio"/>	<input type="radio"/>
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	Cardiac Stents	<input type="radio"/>	<input type="radio"/>
Excess Tearing/Watering	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Glare/Light Sensitivity	<input type="radio"/>	<input type="radio"/>	<b>GASTROINTESTINAL</b>		
Eye Pain or Soreness	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
Chronic Infection of Eye or Lid	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>
Styes or Chalazion	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer	<input type="radio"/>	<input type="radio"/>
Flashes/Floaters in Vision	<input type="radio"/>	<input type="radio"/>	Gastroesophageal Reflux Disease (GERD)	<input type="radio"/>	<input type="radio"/>
Tired Eyes	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<b>GENITOURINARY</b>		
<b>ENDOCRINE</b>			<b>GENITOURINARY</b>		
Elevated Cholesterol	<input type="radio"/>	<input type="radio"/>	Genitals/Kidney/Bladder	<input type="radio"/>	<input type="radio"/>
Thyroid/Other Glands	<input type="radio"/>	<input type="radio"/>	Prostate	<input type="radio"/>	<input type="radio"/>
Diabetes Type I	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
Diabetes Type II	<input type="radio"/>	<input type="radio"/>	<b>BONES/JOINT/MUSCLES</b>		
Other	<input type="radio"/>	<input type="radio"/>	Rheumatoid or Inflammatory Arthritis	<input type="radio"/>	<input type="radio"/>
<b>EARS, NOSE, MOUTH, THROAT</b>			Degenerative or Osteo Arthritis	<input type="radio"/>	<input type="radio"/>
Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>
Sinus Congestion	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
Runny Nose, Post-Nasal Drip	<input type="radio"/>	<input type="radio"/>	<b>LYMPHATIC/HEMATOLOGICAL</b>		
Chronic Cough	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Dry Throat/Mouth	<input type="radio"/>	<input type="radio"/>	Bleeding Problems	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
<b>CONSTITUTIONAL</b>			<b>AUTOIMMUNE</b>		
Fever, Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>	Lupus	<input type="radio"/>	<input type="radio"/>
<b>SKIN</b>			Sjogren's Syndrome	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<b>PSYCHIATRIC</b>		
<b>NEUROLOGICAL</b>			Depression	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Anxiety Disorder	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	Schizophrenia or Bipolar	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<b>CANCER</b>		
<b>CANCER</b>			Type _____		

**Social History**

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer*

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 \_\_\_\_\_Aids \_\_\_\_\_Syphilis \_\_\_\_\_Will discuss with Doctor

*I understand that I may be dilated during my office visit. If I feel that my vision has been impaired, I will make other arrangements for transportation after dilation.*

\_\_\_\_\_  
**Patients Signature Date**

\_\_\_\_\_  
**Doctor's Signature Date**