MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name_____ Today's Date _____
Address_____ Home Phone _____
City, State, Zip_____ Cell Phone _____
Email_____ Work Phone_____
Preferred Method of Contact ☐Home # ☐Cell # ☐Work # ☐Text ☐Email

Birth Date _____ Social Security # _____ Employer_____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐Divorced ☐ Domestic Partner Gender ☐Female ☐Male

Guardian (If Applicable) _____ Last Eye Exam _____
Medical Doctor _____
Clinic/Location_____ Last Medical Exam _____
Pharmacy_____ Pharmacy Location_____
Emergency Contact _____ Phone _____

MEDICAL HISTORY

List all medications you are currently taking: (including oral contraceptives, aspirin, over the counter medications and home remedies). If you have a printed list, we will be happy to make a copy. _____

_____

_____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:_____

_____

List all major injuries, surgeries and/or hospitalizations YOU have had: _____

_____

Are you pregnant and/or nursing? ☐ No ☐Yes If yes, due date_____

List any of the following that YOU have had: crossed eyes, lazy eyes, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____
Have you had any of the following eye surgeries? ☐Cataracts ☐RLE ☐LASIK ☐PRK ☐YAG ☐Laser ☐ RK ☐Corneal ☐ICL ☐Other_____ If yes, when_____
Do you wear glasses? ☐ No ☐ Yes
Do you wear contact lenses? ☐ No ☐ Yes
Type of contact lenses: ☐Monthly ☐ Dailies ☐ Extended Wear ☐Gas Permeable ☐Other_____
Are they comfortable? ☐Yes ☐ No
How much time do you spend on the computer daily? _____

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	RELATIONSHIP	DISEASE/CONDITION	NO	YES	RELATIONSHIP
Blindness	☐	☐	_____	Diabetes	☐	☐	_____
Cataract	☐	☐	_____	Heart Disease	☐	☐	_____
Crossed Eyes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Glaucoma	☐	☐	_____	Kidney Disease	☐	☐	_____
Macular Degeneration	☐	☐	_____	Lupus	☐	☐	_____
Arthritis	☐	☐	_____	Thyroid Disease	☐	☐	_____
Cancer	☐	☐	_____	Other_____			

Please turn this form over and complete side two*

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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, do you have visual difficulty when driving?** ☐**No** ☐ **yes** **If yes, please describe:**_____

Do you use tobacco products? ☐ **No** ☐ **Yes** **If yes, type?** _____

Do you drink alcohol? ☐ **No** ☐ **Yes** **If yes, type?** _____

Do you use illegal drugs? ☐ **No** ☐ **Yes** **If yes, type?** _____

Have you ever been exposed to or infected with: ☐ **Gonorrhea** ☐ **Hepatitis** ☐ **HIV** ☐ **Syphilis**

Review of Systems (Yourself) Do **YOU** currently, or have **you** ever had any problems in the following area:

	Yes	No
GENERAL:		
Fever	☐	☐
Weight Gain/Loss	☐	☐
EAR, NOSE, THROAT:		
Allergies	☐	☐
Sinus	☐	☐
Cough	☐	☐
Dry mouth/throat	☐	☐
Runny nose	☐	☐
CARDIOVASCULAR:		
High BP	☐	☐
Heart surgery	☐	☐
Vascular disease	☐	☐
RESPIRATORY:		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
GENITAL, KIDNEY, BLADDER:		
Kidney stones	☐	☐
Frequent urination	☐	☐
MUSCLES, BONES, JOINTS:		
Arthritis	☐	☐
Joint pain	☐	☐
Head injury	☐	☐
Neck injury	☐	☐
Muscle pain	☐	☐
SKIN:		
Growths	☐	☐
Rashes	☐	☐
Acne	☐	☐
NEUROLOGICAL:		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
PSYCHIATRIC:		
Depression	☐	☐
Anxiety	☐	☐
Insomnia	☐	☐
ADD/ADHD	☐	☐
PTSD	☐	☐
Bipolar	☐	☐

	Yes	No
ENDOCRINE:		
Thyroid	☐	☐
Diabetes	☐	☐
☐ Type 1		
☐ Type 2		
BLOOD/LYMPH:		
Anemia	☐	☐
Cholesterol	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Seasonal allergies	☐	☐
Rheumatoid	☐	☐
AIDS	☐	☐
Allergy Shots	☐	☐
Lupus	☐	☐
GASTROINTESTINAL:		
Diarrhea	☐	☐
Constipation	☐	☐
Ulcer	☐	☐
Reflux	☐	☐
EYES:		
Loss of vision	☐	☐
Blurred vision	☐	☐
Distorted vision/halos	☐	☐
Loss of side vision	☐	☐
Tired eyes	☐	☐
Double vision	☐	☐
Dryness	☐	☐
Mucous discharge	☐	☐
Redness	☐	☐
Sandy or gritty feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign body sensation	☐	☐
Excess tearing	☐	☐
Glare/Light sensitivity	☐	☐
Eye Pain or soreness	☐	☐
Chronic infection of Eye	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐

Patient/Guardian Signature: 1st year _____ **Year:** 2019

Patient/Guardian Signature: 2nd year _____ **Year:** _____

Patient/Guardian Signature: 3rd year _____ **Year:** _____

Patient/Guardian Signature: 4th year _____ **Year:** _____