MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

FULL NAME: _____ TODAY'S DATE_____/_____/_____
ADDRESS: _____ PHONE: _____
CITY, STATE ZIPCODE:_____ CELL: _____
BIRTH DATE: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ SEX: _____MALE _____FEMALE
E-MAIL_____ LAST MEDICAL EXAM: _____ LAST EYE EXAM: _____/_____
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(Please Circle):* Cell Home Phone Email Text Message
MEDICAL DOCTOR:_____ PREVIOUS EYE DR._____
MARITAL STATUS: _____ SPOUSE'S NAME_____
NAMES OF CHILDREN IN LIVING IN YOUR HOUSEHOLD_____
OCCUPATION:_____ ___FULL TIME___PART TIME___RETIRED ___STUDENT SCHOOL:_____
EMPLOYER:_____ WORK PHONE:_____
VISION INSURANCE_____ PRIMARY MEDICAL INSURANCE_____
HOW DID YOU HEAR ABOUT OUR OFFICE? (Please Circle) Insurance website Google Yahoo Walk By Yellow Pages Referral
*WHO MAY WE THANK FOR REFERRING YOU?*_____

INSURED PARTY INFORMATION (if self continue to next section)

INSURED NAME: _____ RELATIONSHIP TO PT._____
INSURED ADDRESS: _____ PHONE:_____ BIRTH DATE:___/___/___(insured)
EMPLOYER:_____ WORK PHONE:_____
EMPLOYER ADDRESS:_____

MEDICAL HISTORY

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):_____
_____
Do you have any environmental allergies or allergies to medications? ___YES___NO If yes, please explain: _____
_____
List all major injuries, surgeries and/or hospitalizations:_____
_____
List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection or eye injury:_____
Do you wear glasses? ____YES ____NO If yes, how old is your present pair?_____
Do you wear contacts? ____YES ____NO If yes, what type do you wear?_____
How many hours per day do you spend on a computer or other electronic devices?_____

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	□	□	_____
Cataracts	□	□	_____
Crossed Eyes	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment/Disease	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Autoimmune Disease	□	□	_____
Thyroid Disease	□	□	_____
Other _____	□	□	_____

Please turn over and complete the other side

SOCIAL HISTORY

Do you drive? □ no □ yes If yes, do you have a visual difficulty when driving? □ no □ yes If yes, please describe:
_____

Do you use tobacco products? □ no □ yes If yes, what type? Amount? How many years? _____
Do you drink alcohol? □ no □ yes If yes, what type? Amount? How many years? _____
Do you use illegal drugs? □ no □ yes If yes, what type? Amount? How many years? _____

REVIEW OF SYSTEMS

Do you currently or have any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	□	□	□
INTEGUMENTARY (Skin)	□	□	□
NEUROLOGICAL			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
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	□	□	□
Glare/Light Sensitivity	□	□	□
Eye Pain/Soreness	□	□	□
Chronic Infection of Eye or Lid	□	□	□
Chronic Stye/Chalazion	□	□	□
Flashes/Floaters in Vision	□	□	□
Tired Eyes	□	□	□
ENDOCRINE			
Thyroid Dysfunction	□	□	□
Other Gland Dysfunction	□	□	□

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	□	□	□
Sinus Congestion	□	□	□
Runny Nose	□	□	□
Post Nasal Drip	□	□	□
Chronic Cough	□	□	□
Dry Throat/Mouth	□	□	□
RESPIRATORY			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema	□	□	□
VASCULAR / CARDIOVASCULAR			
Diabetes	□	□	□
Heart Pain	□	□	□
High Blood Pressure	□	□	□
Vascular Disease	□	□	□
GASTROINTESTIONAL			
Diarrhea	□	□	□
Constipation	□	□	□
GENITOURINARY			
Kidney/Bladder	□	□	□
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	□	□	□
Osteoarthritis	□	□	□
Muscle/Joint Pain	□	□	□
LYMPHATIC / HEMATOLOGIC			
Anemia	□	□	□
Bleeding Problems	□	□	□
ALLERGIC / IMMUNOLOGIC	□	□	□
PSYCHIATRIC	□	□	□

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

_____
_____
_____
_____
_____

_____ _____
Doctor's Signature Date