Medical History Questionnaire

(If you require assistance with this questionnaire, please don't hesitate to ask us to help.)

Name _____ Today's Date _____/_____/_____

Address _____ City _____ ST _____ Zip_____

Phone Numbers: (___) _____Home/Evening (___) _____ Daytime (___) _____ Cell
Race/Ethnicity: _____ Gender: ☐Male ☐ Female Date of Birth: _____/_____/_____

Email Adress_____*

Name of your physician referring you _____ Physician Phone _____

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

Date of last eye exam ____/_____/_____

MEDICAL AND PAST HISTORY

List any medications you take: _____ _____ _____
_____ _____ _____
List all major illnesses and injuries _____ _____ _____
_____ _____ _____

If diabetic, please complete the following information:
Type 1 ❒ Yes ❒ No Type II ❒ Yes ❒ No Date of onset: ____/_____/_____
For report purposes: Name and address of physician managing your diabetes care: _____
_____
Date of last blood work: ____/_____/_____ Results: _____ Frequency: _____

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 _____
Do you have allergies to any medications ❒ Yes ❒ No _____
If YES, please list: _____ _____ _____
_____ _____ _____
_____ _____ _____

Many medical conditions and medications used to treat them can affect your eyes and vision. Some conditions are inherited. Your "Family History" helps the doctor look for indicators that may exist or present as you age.

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Blindness	❒	❒	_____	Cataract	❒	❒	_____
Glaucoma	❒	❒	_____	Arthritis	❒	❒	_____
Macular degeneration	❒	❒	_____	Cancer	❒	❒	_____
Retinal detachment	❒	❒	_____	Diabetes	❒	❒	_____
Heart attacks	❒	❒	_____	Blood disease	❒	❒	_____
High blood pressure	❒	❒	_____	Kidney disease	❒	❒	_____
Lupus	❒	❒	_____	Stroke	❒	❒	_____
Sjogren's Syndrome	❒	❒	_____	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 _____

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

<u>*Email address is for email reminder and to order your contact we don't share it.</u>

Name _____ Today's Date _____/_____/_____

(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 use tobacco products? ❒ Yes ❒ No

If YES, how many packs a day? _____

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

Other? ❒ 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	❒	❒
Styes	❒	❒
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:

_____

_____

_____