

Medical History Questionnaire

(Please Print)

Name: _____ Date: ____/____/____ Date of Birth: ____/____/____
Last medical exam: ____/____/____ Medical Doctor (name,location): _____
Last eye exam: ____/____/____ Last Eye Care Provider: _____
Pharmacy (name, location, phone): _____

Past Eye History

Have you ever had any eye injuries? No Yes: (list) _____
Have you ever had any eye surgeries? No Yes (list) _____
List any eye drops you use : _____
Do you wear glasses? No Yes / How old is you present pair of lenses? _____
Do you wear contact lenses? No Yes / How old is your present pair of lenses? _____
Type of contact lenses: Rigid Soft Wearing Schedule: Remove daily Sleep in lenses
How often do you throw away your lenses? _____ Are your lenses comfortable? _____
Do you have or ever had any of the following eye conditions or diseases? Please check all that apply.
 Cataracts Glaucoma Macular Degeneration Retinal Detachment/ Disease Dry Eyes Eye Infections
 Loss of Vision/Side Vision Itchy Eyes Double Vision Blurred Vision Flashes/Floaters Crossed Eyes
 Lazy Eyes Drooping Eyelid Other _____

Past Medical History

List all medications: _____

Allergies: None Yes(list) _____

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

Are you pregnant ? No Yes / Weeks _____ Are you Nursing? No Yes

Do you have any medical conditions? Please check all that apply. Diabetes High Blood Pressure Heart Disease
 High Cholesterol Thyroid Disorder Autoimmune Disease (name: _____) Please list any additional
medical conditions. _____

Family History: (Check all that apply to your blood relatives)

Blindness Glaucoma Macular Degeneration Cataracts Lazy Eye Retinal Disease/Detachment Diabetes
 Heart Disease Stroke High Blood Pressure Arthritis Kidney Disease Thyroid Disorder Autoimmune
 Other _____

Social History

Smoking Status: Current every day smoker Current some day smoker Former Smoker Never smoked
 Smoker, current status unknown Unknown if ever smoked

If smoker: How much? _____ How long? _____ When quit? _____

Alcohol Use: None Occasional drinker Everyday drinker Type _____ How long? _____

Drugs: No Yes: type/amount/how long: _____

Check if you have ever been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis

OVER

Review of Systems

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

Constitution

- Fatigue/ Weakness Yes No
- Fever Yes No
- Weight gain/loss Yes No
- Jaw pain when chewing Yes No
- Scalp Tenderness Yes No

Skin

- Rashes/Sores Yes No
- Rosacea Yes No
- Hives/Eczema Yes No

Neurological

- Headaches/Migraines Yes No
- Seizures Yes No
- Multiple Sclerosis Yes No
- Numbness Yes No
- Tremors Yes No

Eyes

- Other not previous listed Yes No

Ear, Nose and Throat

- Hard of Hearing Yes No
- Ringing in Ears Yes No
- Dizziness/Vertigo Yes No
- Sinus Congestion/Pressure Yes No

Respiratory

- Asthma Yes No
- Chronic Bronchitis Yes No
- Emphysema Yes No
- Cough Yes No
- Congestion Yes No
- Sleep Apnea Yes No

Cardiovascular

- Heart attack Yes No
- Heart Disease Yes No
- Stroke Yes No
- High blood pressure Yes No
- Irregular heart beat Yes No
- Vascular disease Yes No

Gastrointestinal

- Esophageal Reflux Yes No
- Digestive Disorder Yes No
- Ulcer Yes No
- Cirrhosis Yes No
- Hepatitis Yes No
- Genitourinary**
- Kidney Stones Yes No
- Urinary Disorder Yes No
- History of STD's Yes No

MusculoSkeletal

- Rheumatoid Arthritis Yes No
- Osteoarthritis Yes No
- Myasthenia Gravis Yes No
- Fibromyalgia Yes No

Lymphatic/Hematologic

- Anemia Yes No
- High Cholesterol Yes No
- Easy Bruising Yes No
- Aspirin Use Yes No

Endocrine

- Thyroid (low) Yes No
- Thyroid (high) Yes No
- Diabetes Yes No
- Pituitary Disorder Yes No

Psychiatric

- Anxiety Yes No
- Depression Yes No
- Bipolar Yes No
- Schizophrenia Yes No
- Difficulty Sleeping Yes No

Immunologic

- Allergies Yes No
- Hay Fever Yes No
- Lupus Yes No
- Sarcoidosis Yes No
- Sjogrens Yes No

Other

- Cancer Yes No
- _____
- _____

Explanations:

Patient/Guardian Signature

Date

Doctor Signature

Date Reviewed