Medical History Questionnaire

(Please Print)

Name _______________ Date _______________
Date of Birth _______________ Last medical exam _______________ Last eye exam _______________
Medical Doctor (name, address, phone) _______________ Pharmacy (name and phone) _______________

Past Eye History (circle Y or N or ?)

Have **YOU** ever had:

				Explain
Crossed Eyes	Y	N	?	
Lazy Eyes	Y	N	?	
Drooping Eyelid	Y	N	?	
Prominent Eyes	Y	N	?	
Glaucoma	Y	N	?	
Macular Degeneration	Y	N	?	
Retinal Detachment/ Disease	Y	N	?	
Cataracts	Y	N	?	
Eye Infections	Y	N	?	
Eye Injury	Y	N	?	
Eye Surgery	Y	N	?	
Loss of Vision/Side Vision	Y	N	?	
Dry Eyes	Y	N	?	
Itching	Y	N	?	
Double Vision	Y	N	?	
Blurred Vision	Y	N	?	
Flashes/Floaters	Y	N	?	

Any other eye problems not mentioned above? _______________
Do you wear glasses? Y / N If yes, how old is you present pair of lenses? _______________
Do you wear contact lenses? Y / N If yes, how old is your present pair of lenses? _______________
Type of contact lenses: Rigid or Soft Wearing Schedule: Remove daily or sleep in lenses
How often do you throw away your lenses? _______________ Are your lenses comfortable? Y / N
List any eye drops you use: _______________

Past Medical History

List any medicines **YOU** take (including oral contraceptives, aspirin, over the counter medications and home remedies): _______________

List any allergies to any medications and explain: _______________

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

Are you pregnant or nursing? Y / N
List any medical problems/ diagnoses you have had (i.e. high blood pressure, diabetes, etc.): _______________

Family History

Please note any **family history (blood relatives – parents, grandparents, siblings and/or children, living or deceased)** for the following medical condition:

Disease/Condition				Relationship To You
Blindness	Y	N	?	

Please turn form over and complete side 2

 Medical History Questionnaire

Family History (Continued)

Disease/Condition				Relationship To You
Cataracts	Y	N	?	______
Crossed Eyes	Y	N	?	______
Glaucoma	Y	N	?	______
Macular Degeneration	Y	N	?	______
Retinal Detachment/Disease	Y	N	?	______
Arthritis	Y	N	?	______
Cancer	Y	N	?	______
Diabetes	Y	N	?	______
Heart Disease	Y	N	?	______
High Blood Pressure	Y	N	?	______
Kidney Disease	Y	N	?	______
Lupus	Y	N	?	______
Thyroid Disease	Y	N	?	______
Other? ______				______

Social History

Occupation ______ Marital Status S M D W

Do you drive? Y / N If yes, do you have visual difficulty when driving? Y / N If yes, please describe: ______

Do you use tobacco products? Y / N If yes, type/amount/how long: ______

Do you drink alcohol? Y / N If yes, type/amount/how long: ______

Do you use any other drugs? Y / N If yes, type/amount/how long: ______

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

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If yes, please explain and list medications)

				Explanation/Medications
General/Constitutional				
Sudden Weight Gain	Y	N	?	______
Unexplained Weight Loss	Y	N	?	______
Other ? ______				______
Integumentary (Skin)	Y	N	?	______
Neurologic				
Headaches/Migraines	Y	N	?	______
Seizures	Y	N	?	______
Multiple Sclerosis	Y	N	?	______
Other ? ______				______
Eyes				
Problem/Condition not listed?	Y	N	?	______
Ear, Nose, Mouth, Throat				
Sinus Congestion	Y	N	?	______
Dry Throat/Mouth	Y	N	?	______
Other ? ______				______
Respiratory				
Asthma	Y	N	?	______
Chronic Bronchitis	Y	N	?	______
Emphysema	Y	N	?	______
Other ? ______				______
Vascular				
Heart Attack	Y	N	?	______
Heart Disease	Y	N	?	______
Stroke	Y	N	?	______
Heart Pain/Angina	Y	N	?	______

Please continue on page 3

 Name ______________________

Review of Systems (continued) — **Explanation/Medications**

Vascular
- High Blood Pressure Y N ? ______
- Vascular Disease Y N ? ______
- Other ? ______ ______

Gastrointestinal (Stomach/Intestines)
- Ulcer Y N ? ______
- Esophageal Reflux Y N ? ______
- Digestive Disorder Y N ? ______
- Cirrhosis Y N ? ______
- Hepatitis Y N ? ______
- Other ? ______ ______

Genitourinary (Genitals, Kidney, Bladder)
- Kidney Disorder Y N ? ______
- Urinary Disorder Y N ? ______
- Other ? ______ ______

Bones / Joints/ Muscles
- Rheumatoid Arthritis Y N ? ______
- Osteoarthritis Y N ? ______
- Myasthenia Gravis Y N ? ______
- Other ? ______ ______

Lymphatic / Hematologic (Blood)
- Anemia Y N ? ______
- High Cholesterol Y N ? ______
- Other ? ______ ______

Endocrine (Glands)
- Thyroid Y N ? ______
- Diabetes Y N ? ______
  - (How long/how controlled) ______
- Other ? ______ ______

Psychiatric
- Depression Y N ? ______
- Anxiety Y N ? ______
- Other ? ______ ______

Allergic/Immunologic
- Allergies Y N ? ______
- Hay Fever Y N ? ______
- Lupus Y N ? ______
- Sarcoidosis Y N ? ______
- Sjogrens Y N ? ______
- Other ? ______ ______

Other
- Cancer Y N ? ______
- ______ ______

____
Patient/Guardian Signature

____
Date

____
Doctor's Signature

____
Date Reviewed

Do not write on this page. Staff use only

Medical History Updates