

Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ / _____

Birth Date: _____ / _____ / _____ Date of Last Eye Exam: _____ / _____ / _____

Name of Medical Doctor: _____ Dr's Phone Number: _____

Dr's Address : _____ Last Medical Exam: _____ / _____ / _____

Patient Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including aspirin, supplements, oral contraceptives, over the counter medications and home remedies):

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

Check any of the following you have had: crossed eyes lazy eye drooping eyelid prominent eyes glaucoma retinal detachment / disease
 macular degeneration cataracts eye infections eye injury _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair? _____

Do you wear prescription sunglasses? no yes If yes, how old is your present pair? _____

Do you wear sports or safety glasses? no yes If yes, how old is your present pair? _____

Do you wear contact lenses? no yes If yes, how old is your present pair? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no yes

Do you use a computer at home or work? no yes If yes, how many hours per day? _____

Do you experience any eye, neck or back difficulties when using the computer? no yes If yes, please explain: _____

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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment / Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

(Please turn this form over and complete side two)

Name: _____ Birth Date: _____ / _____ / _____

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.

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 / amount / how long: _____

Do you drink alcohol? no yes If yes, type / amount / how long: _____

Do you use illegal drugs? no yes If yes, type / amount / how long: _____

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

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

| SYSTEM | NO | YES | ? | NO | YES | ? |
|----------------------------------|--------------------------|--------------------------|--------------------------|----|-----|---|
| CONSTITUTIONAL | | | | | | |
| Fever, Weight Loss / Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| INTEGUMENTARY (Skin) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| NEUROLOGICAL | | | | | | |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| EYES | | | | | | |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Distorted Vision / Halos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Loss of Side Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Mucous Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sandy or Gritty Feeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Foreign Body Sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Excess Tearing / Watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Glare / Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Eye Pain or Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chronic Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sties or Chalazion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Flashes / Floaters in Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Tired Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| ENDOCRINE | | | | | | |
| Thyroid / Other Glands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| EARS, NOSE, MOUTH, THROAT | | | | | | |
| Allergies / Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Post -Nasal Drip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Dry Throat / Mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| RESPIRATORY | | | | | | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| VASCULAR / CARDIOVASCULAR | | | | | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Heart Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| GASTROINTESTINAL | | | | | | |
| Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| GENITOURINARY | | | | | | |
| Genital / Kidney / Bladder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| BONES / JOINTS / MUSCLES | | | | | | |
| Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| LYMPHATIC / HEMATOLOGIC | | | | | | |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| ALLERGIC / IMMUNOLOGIC | | | | | | |
| PSYCHIATRIC | | | | | | |

If you answered yes to any of the above or have a condition not listed, please explain and list medications: _____

Doctor's Signature _____

Date _____