Medical History Questionnaire

GT:	Y	N	M
CL:	Y	N	M

Name: ________________________________ Birth Date: _____/_____/_______ Today's Date: ____________________

Race/Ethnicity: _______________________ Last Eye Exam: ________________________________

Currently wearing: ☐Glasses ☐Contact lenses Last Eye Doctor: ________________________________

Preferred Pharmacy: ________________________ Current Medical Dr.:______________________________

(please include location) __________________ Last Medical Exam: _____________________________

Medical History

Allergies to medications? ☐Yes ☐ No If yes, please list/explain: ____

____

Please list all medications you are currently taking (including aspirin, contraceptives, over the counter medications, supplements):

____

____

____

Please list all major surgeries and/or hospitalizations:

____

____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship to You**
Blindness	☐	☐	☐	______________________
Cataract	☐	☐	☐	______________________
Crossed eye/lazy eye	☐	☐	☐	______________________
Glaucoma	☐	☐	☐	______________________
Macular Degeneration	☐	☐	☐	______________________
Retinal Detachment/Disease	☐	☐	☐	______________________

Systemic Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship to You**
Arthritis	☐	☐	☐	______________________
Cancer	☐	☐	☐	______________________
Diabetes	☐	☐	☐	______________________
Heart Disease	☐	☐	☐	______________________
High Blood Pressure	☐	☐	☐	______________________
Thyroid Disease	☐	☐	☐	______________________
Other: ______________	☐	☐	☐	______________________

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you wish.

☐ Yes, I would prefer to discuss my social history directly with the doctor (check box and complete side 2)

Do you drive? ☐Yes ☐ No If yes, do you have any difficulty when driving? ☐Yes ☐No If yes, please describe:

____

Do you use tobacco products? ☐Yes ☐No If yes, type/amount/how long:

Do you drink alcohol? ☐Yes ☐No If yes, type/amount/how long:

Do you use illicit/illegal drugs? ☐Yes ☐No If yes, type/amount/how long:

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

Have you ever been exposed to or infected with any sexually transmitted disease(s)? ☐Yes ☐No

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

Medical History Questionnaire

Review of Systems

Please indicate if you have problems in any of the following areas:

System	Yes	No	Not Sure
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Skin Disorders/Disease	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Blurred vision	☐	☐	☐
Loss of vision/side vision	☐	☐	☐
Distorted vision/haloes	☐	☐	☐
Flashes of light	☐	☐	☐
Floaters in vision	☐	☐	☐
Dry/Sandy/Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Eye pain/soreness/aching	☐	☐	☐
Redness	☐	☐	☐
Tearing/watering eyes	☐	☐	☐
Mucous discharge	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Tired eyes	☐	☐	☐
Sties/eyelid infection(s)	☐	☐	☐
Glaucoma	☐	☐	☐
Retinal disorder/disease	☐	☐	☐
Endocrine			
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐
Other glandular disease	☐	☐	☐
Immune System disorders	☐	☐	☐

	Yes	No	Not Sure
Ears, Nose, Mouth, Throat			
Allergies (Seasonal/Environmental)	☐	☐	☐
Sinusitis/sinus disorder	☐	☐	☐
Head cold	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/throat	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Kidney/bladder/genital disorder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Other arthritic condition	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
Psychiatric disorder/disease	☐	☐	☐

Please list any other pertinent information that you feel may be important in the care of your eyes (including history of prior diagnoses of cataracts, high pressure in eyes, ocular growths, ocular surgery, etc):

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(Office use only)

GT: Y N M **GLC** **DM**

CL: Y N M