

Medical History Questionnaire

Name: _____
Birth Date: ____/____/____ Last Eye Doctor: _____
Medical Dr. and Location: _____

Today's Date: _____
Last Eye Exam: ____/____
Last Medical Exam: ____/____

Medical History

Allergies to medications? Yes No If yes, explain: _____

Major injuries, surgeries and/or hospitalizations you have had: _____

Medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

Check any of the following that you have had: Reading Difficulty Crossed Eyes Lazy Eye Glaucoma
 Retinal Disease Cataracts Eye Injury

Are you pregnant and/or nursing? Yes No

Do you wear glasses? Yes No

If yes, how old is the present pair of glasses? _____

How many pair of glasses do you currently use? _____

Do you wear contact lenses? Yes No

If yes, how old is the present pair of contacts? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No

Have you had any refractive surgery? Yes No Is safety protection a concern at work? Yes No

Do you perform fine close-up work? Yes No Are you outdoors all or part of the time? Yes No

Do you have trouble reading signs when driving at night? Yes No Are you sensitive in bright sunlight? Yes No

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. (check box)

Do you drive Yes No If yes, do you have visual 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: _____

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

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ears, Nose, Throat, Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lymphatic/Hematologic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular/Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bones/Joints/Muscles	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Allergic/Immunologic	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Family History

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

Ocular Disease/Condition		Systemic Disease/Condition			
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Retinal Detachment/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

DO NOT WRITE BELOW THIS LINE (Doctors Comments):

I have reviewed this history with the patient: _____

Doctor's Signature/Date