MEDICAL HISTORY QUESTIONNAIRE

Name:________________________________ Today's Date: _____/____/_____ Birthdate: _____/ _____/_____

Last Pupil Dilation: _____/_____/_____ Last Medical Exam: _____/_____/_____ Last Eye Exam: _____/_____/_____

Primary Care Physician: ____________________________ PCP Location: ______________________________________

What is the primary reason for your visit today? ____

____

MEDICAL HISTORY

Please list all medications you take, including over the counter, eye drops and vitamins.

____

Do you have any allergies to medications? ☐ NO ☐ YES If yes, explain: ____________________________________

List all eye injuries and surgeries you have had:

____

Circle any of the following that you have currently or have had:

drooping eyelids keratoconus eye infections dry eyes

Are you pregnant or nursing? ☐ NO ☐ YES

Do you wear glasses? ☐ NO ☐ YES If yes, how old are your current lenses? _________ Frames?__________

Do you wear contacts? ☐ NO ☐ YES If yes, how old is your present pair of lenses?______________________

Type of contact lenses: ☐ Rigid ☐ Soft Brand: ____________________ Replacement schedule: _________________

Are they comfortable? ☐ NO ☐ YES Do you sleep in them? ☐ NO ☐ YES

FAMILY HISTORY

Please note any family history (you, parents, or grandparents: but only blood relatives, living or deceased) and whether it be paternal or maternal for the following conditions:

DISEASE/CONDITION	Self	Mom	Dad	Other	DISEASE/CONDITION	Self	Mom	Dad	Other
Blindness	_____	_____	_____	_____	High Blood Pressure	_____	_____	_____	_____
Cataracts	_____	_____	_____	_____	Heart Disease	_____	_____	_____	_____
Strabismus (Crossed Eyes)	_____	_____	_____	_____	Diabetes, Type? ___________	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	Kidney Disease	_____	_____	_____	_____
Amblyopia (Lazy Eye)	_____	_____	_____	_____	Lupus	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	Thyroid Disease	_____	_____	_____	_____
Retinal Detachment/Disease	_____	_____	_____	_____	High Cholesterol	_____	_____	_____	_____
Arthritis, Type? ___________	_____	_____	_____	_____	Other	_____	_____	_____	_____
Cancer, Type? ___________	_____	_____	_____	_____					

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion with your 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, packs per day______ how long: ____________________

Do you drink alcohol? ☐ NO ☐ YES If yes, type/amount/how long: _____________________________________

Do you use illicit drugs? ☐ NO ☐ YES If yes, type/amount/how long: __________________________________

Have you ever been exposed to or infected with? Gonorrhea Hepatitis HIV Syphilis N/A

REVIEW OF SYSTEMS — Check any of the following you are currently experiencing.

Eyes

Sudden Loss of Vision	☐	Allergies/Hay Fever	☐
Blurred Vision	☐	Sinus Congestion	☐
Distorted Vision	☐	Dry Throat/Mouth	☐
Halos	☐	Asthma	☐
Loss of Side Vision	☐	Chronic Bronchitis	☐
Double Vision	☐	Emphysema	☐
Dryness	☐	Skin Problems	☐
Mucous Discharge	☐	Headaches	☐
Tired Eyes	☐	Migraines	☐
Redness	☐	Vascular Disease	☐
Sandy/Gritty Feeling	☐	Seizures	☐
Itching	☐	Digestive Problems	☐
Burning	☐	Constipation	☐
Foreign Body Sensation	☐	Kidney Conditions	☐
Excess Tears/Watering	☐	Bladder Conditions	☐
Glare/Light Sensitive	☐	Rheumatoid Arthritis	☐
Eye Pain or Soreness	☐	Joint Pain	☐
Chronic Eye Infection	☐	Bone Loss	☐
Chronic Eyelid Infection	☐	Muscle Pain	☐
Sties or Chalazion	☐	Anemia	☐
Flashes	☐	Fever	☐
Floaters	☐	Bleeding Problems	☐

Please list any other conditions, symptoms, and concerns below.

____

____

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I have reviewed this form and all information is correct to the best of my ability.
Please initial and date only once below.

______________________________ ______________

Patient Signature (year one) Date

______________________________ ______________

Patient Signature (year two) Date