Medical History Questionnaire

Required by insurances; very important to our doctors. Thank you.

Name: ____ Date: ____________

Reason for Visit: ☐ General Examination ☐ Contact Lens fitting/evaluation

☐ __________ ☐ Eye Injury/infection/pain ☐ LASIK evaluation

Date of last eye exam? __________ Where? ______ Eye Doctor: _________________

Date of last medical exam? ___________________ Medical Doctor: ______________

Medical History

Do you have any allergies to medications? **YES** **NO** If YES, list:______________________

List any medications you take (including over the counter, vitamins, supplements) **and Why:**

____

____

____

Are you diabetic? **YES** **NO** If yes, since when? __________________

List all major injuries, surgeries, hospitalizations you have had: ______________________________

____

List any of the following you have had: eye surgeries, eye injuries, crossed eyes, lazy eye, glaucoma, cataracts, retinal disease: ____

Are you pregnant or nursing? **YES** **NO**

Do you wear glasses? **YES** **NO** If yes, how old is your present pair? __________

Do you wear contact lenses? **YES** **NO** If yes, how old is your present pair? __________

Type of contacts: Rigid (RGP), Disposable, Toric, Other? _____ Are they comfortable? **YES** **NO**

Family History

DISEASE/CONDITON	Mom	Dad	MGM	MGF	PGM	PGF	sibling
Blindness							
Cataract							
Crossed Eyes							
Glaucoma							
Macular Degeneration							
Retinal Detachment/Disease							
Arthritis							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Thyroid Disease							
Other							

MGM = Maternal grandmother (mom's side)

MGF = Maternal grandfather (mom's side)

PGM = Paternal grandmother (dad's side)

PGF = Paternal grandfather (dad's side)

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? **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: ____________________________________

Do you use illegal drugs? **YES NO** If yes, type/amount, how long: ____________________________________

Have you ever been exposed to or infected with: ❑ AIDS/HIV ❑ Gonorrhea ❑ Hepatitis ❑ Syphilis ❑ No

Review of Systems

Do you currently, or have you ever had any problems in the following areas? Please circle y**es (Y)** or **no (N)**.

CONSTITUTIONAL
- **Y N** Fever, Weight Loss/Gain

EARS/NOSE/MOUTH/THROAT
- **Y N** Sinus Congestion
- **Y N** Dry mouth/throat

CARDIOVASCULAR
- **Y N** Heart Pain
- **Y N** High Blood Pressure
- **Y N** Vascular Disease
- **Y N** Heart Surgery

RESPIRATORY
- **Y N** Asthma
- **Y N** Chronic Bronchitis
- **Y N** Emphysema

GENITOURINARY
- **Y N** Dialysis/kidney failure

GASTROINTESTINAL
- **Y N** Diarrhea
- **Y N** Constipation

MUSCULOSKELETAL
- **Y N** Rheumatoid Arthritis
- **Y N** Muscle Pain
- **Y N** Joint Pain

INTEGUMENTARY (SKIN)
- **Y N** Eczema
- **Y N** Skin Cancer

NEUROLOGICAL
- **Y N** Headaches
- **Y N** Migraines
- **Y N** Seizures

PSYCHIATRIC
- **Y N** Depression/Anxiety

ENDOCRINE
- **Y N** Diabetes
- **Y N** Hyper/Hypo Thyroid

HEMATOLOGIC/LYMPHATIC
- **Y N** Anemia
- **Y N** Bleeding Problems

ALLERGIC/IMMUNOLOGIC
- **Y N** Lupus
- **Y N** Hay Fever/Allergies

EYES
- **Y N** Glaucoma
- **Y N** Cataracts
- **Y N** Diabetic Retinopathy
- **Y N** Retinal Detachment
- **Y N** Retinal Disease
- **Y N** Eye Injury
- **Y N** Blindness
- **Y N** Strabismus/crossed eyes
- **Y N** Lazy Eye/amblyopia
- **Y N** Blurry vision with glasses
- **Y N** Tired eyes
- **Y N** Decreased vision
- **Y N** Dryness
- **Y N** Burning
- **Y N** Itching
- **Y N** Double Vision
- **Y N** Eye Pain
- **Y N** Floaters
- **Y N** Flashes of Light
- **Y N** History of Eye Surgeries

Other: ________________

If you answered YES (Y) to any of the above or have a condition not listed, please explain:

____

____