Chart #_____ Today's Date: ____/____/____

Medical History Questionnaire

Name: _____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____

Preferred Pharmacy _____ Last Medical Exam: ____/____/____

Medical History

Do you have any allergies to medications? ❑ no ❑ yes If yes, please list: _____

_____

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

_____

_____

_____

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

_____

_____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, macular degeneration, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ❑ no ❑ yes

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

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

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other

Family Eye 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	❑	❑	_____
Cataract	❑	❑	_____
Crossed Eyes - Lazy Eye	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Detachment/Disease	❑	❑	_____
Arthritis	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____
Kidney Disease	❑	❑	_____
Lupus	❑	❑	_____
Thyroid Disease	❑	❑	_____
Eye or Lid Cancer	❑	❑	_____
Other _____	❑	❑	_____

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

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? ❑ 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 / frequency / amount _____

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

Review of Systems

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

SYSTEM	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss / Gain	❑	❑
Skin Rash or other abnormality	❑	❑
NEUROLOGICAL		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
EYES		
Loss of Vision	❑	❑
Blurred Vision	❑	❑
Distorted Vision / Halos	❑	❑
Loss of Side Vision	❑	❑
Double Vision	❑	❑
Dryness	❑	❑
Mucous Discharge	❑	❑
Redness	❑	❑
Sandy or Gritty Feeling	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body Sensation	❑	❑
Excess Tearing / Watering	❑	❑
Glare / Light Sensitivity	❑	❑
Eye Pain or Soreness	❑	❑
Chronic Infection of Eye or Lid	❑	❑
Stye or Chalazion	❑	❑
Flashes / Floaters in Vision	❑	❑
Tired Eyes	❑	❑
ENDOCRINE		
Thyroid / Other Glands	❑	❑

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies / Hay Fever	❑	❑
Sinus Congestion	❑	❑
Runny Nose	❑	❑
Post-Nasal Drip	❑	❑
Dry Throat / Mouth	❑	❑
RESPIRATORY		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Chronic Cough	❑	❑
Emphysema	❑	❑
VASCULAR / CARDIOVASCULAR		
Chest Pain	❑	❑
High Blood Pressure	❑	❑
Irregular Heartbeat	❑	❑
Vascular Disease	❑	❑
GASTROINTESTINAL		
Diarrhea	❑	❑
Constipation	❑	❑
GENITOURINARY		
Genitals / Kidney / Bladder	❑	❑
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	❑	❑
Muscle Pain	❑	❑
Joint Pain	❑	❑
LYMPHATIC / HEMATOLOGIC		
Anemia	❑	❑
Bleeding Problems	❑	❑
PSYCHIATRIC		
Depression / Anxiety	❑	❑

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

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date