Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____

Address: _____ Phone: _____

_____ Work Phone: _____

Birth Date: ____/____/____ Social Security#: _____/_____/_____ Last Eye Exam: _____/_____/_____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: _____/_____/_____

Medical History

Do you have any allergies to medications?   no   yes If yes, explain:

_____

_____

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

_____

_____

_____

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

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, 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   Are they comfortable?   yes   no

Family 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				_____
Glaucoma				_____
Macular Degeneration				_____
Retinal Detachment/Disease				_____
Arthritis				_____
Cancer				_____
Diabetes				_____
Heart Disease				_____
High Blood Pressure				_____
Kidney Disease				_____
Lupus				_____
Thyroid Disease				_____
Other _____				_____

Please turn this form over and complete side two

Social History *This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History informtion 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 use illegal drugs?　　no　　yes　　If yes, type/amount/how long:
_____

Have you ever been exposed to or infected with:　　　　Gonorrhea　　　Hepatitis　　　HIV　　　Syphilis

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

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				**EARS, NOSE, MOUTH, THROAT**			
Fever, Weight Loss/Gain				Allergies/Hay Fever			
INTEGUMENTARY (Skin)				Sinus Congestion			
NEUROLOGICAL				Runny Nose			
Headaches				Post-Nasal Drip			
Migraines				Chronic Bronchitis			
Seizures				Dry Throat/Mouth			
EYES				**RESPIRATORY**			
Loss of Vision				Asthma			
Blurred Vision				Chronic Bronchitis			
Distorted Vision/Halos				Emphysema			
Double Vision				**VASCULAR/CARDIOVASCULAR**			
Loss of Side Vision				Diabetes			
Dryness				Heart Pain			
Mucous Discharge				High Blood Pressure			
Redness				Vascular Disease			
Sandy or Gritty Feeling				**GASTROINTESTINAL**			
Itching				Diarrhea			
Burning				Constipation			
Foreign Body Sensation				**GENITOURINARY**			
Excess Tearing/Watering				Genitals/Kidney/Bladder			
Glare/Light Sensitivity				**BONES/JOINTS/MUSCLES**			
Eye Pain or Soreness				Rheumatoid Arthritis			
Chronic Infection of Eye or Lid				Muscle Pain			
Flashes/Floaters in Vision				**LYMPHATIC/HEMATOLOGIC**			
Tired Eyes				Anemia			
ENDOCRINE				Bleeding Problems			
Thyroid/Other Glands				**ALLERGIC/IMMUNOLOGIC**			
				PSYCHIATRIC			

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

_____
_____
_____

_____   _____
　　　　　　　　Doctor's Signature　　　　　　　　　　　　　　　　　　　　　　Date