MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Birth Date: _____/_____/_____ SS#:_____/_____/_____

Last Eye Doctor: _____ Last Eye Exam: _____/_____
City / State Month Year

Current Medical Doctor: _____ Last Medical Exam: _____/_____
City / State Month Year

Pharmacy: _____ _____ _____ _____
Location Phone mail order / 90 day supply

Medical History

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

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

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

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 directly with my doctor. (Check box)
Do you drive? □ yes □ no If yes, do you have any visual difficulty when driving? □ yes □ no
Please describe: _____
Are you currently pregnant or nursing? □ yes □ no
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 recreational drugs? □ yes □ no If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ None

Personal Eye History

Check any of the following that you have had:

□ Reading Difficulty	□ Crossed Eyes	□ Glaucoma
□ Lazy Eye	□ Diabetic Bleeding	□ Cataracts
□ Eye Injury	□ Glare at night	□ Dry Eyes
□ Double Vision	□ Macular Degeneration	□ Other _____

Do you wear prescription glasses? □ yes □ no Do you wear drug store reading glasses? □ yes □ no

Do you have history of needing prism in your prescription glasses for double vision / vision therapy? □ yes □ no

Do you wear contact lenses? □ yes □ no If yes, □ soft □ hard Brand? _____ How Old? _____

Have you had any eye surgeries?

□ LASIK / RK / PRK	□ Muscle Surgery	□ Glaucoma Surgery
□ Cataract	□ Diabetic Laser	□ Retinal Detachment
□ Eye Injections	□ Eyelid Lift	□ Punctal Plugs

DO NOT WRITE BELOW THIS LINE (Doctor's Comments)

I have reviewed this history with the patient as documented above: _____
Doctor's Signature / Date

_____

_____

*** Please turn this form over and complete side 2 ***

Medical History

	You	Family (blood relatives)	Comments
Eyes			
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Dry Eye Syndrome	☐	☐	_____
Flashes / Floaters	☐	☐	_____
Halos / Glare	☐	☐	_____
Night Blindness	☐	☐	_____
Recurrent Styes	☐	☐	_____
Corneal Dystrophy (Fuchs')	☐	☐	_____
Auto Immune			
Rheumatoid Arthritis	☐	☐	_____
Lupus	☐	☐	_____
Psoriatic Arthritis	☐	☐	_____
Lyme Disease	☐	☐	_____
Sarcoidosis	☐	☐	_____
Sjogren's Syndrome	☐	☐	_____
Chrone's Disease	☐	☐	_____
Neurological			
Epilepsy or seizures	☐	☐	_____
Stroke	☐	☐	_____
Migraine headaches	☐	☐	_____
Cardiovascular			
High Blood Pressure	☐	☐	_____
Heart Attack	☐	☐	_____
High Cholesterol	☐	☐	_____
Endocrine			
Diabetes	☐	☐	_____
Thyroid	☐	☐	_____
Grave's Disease	☐	☐	_____
Mental Health			
Depression	☐	☐	_____
Bipolar	☐	☐	_____
Anxiety disorder	☐	☐	_____
Respiratory			
Asthma	☐	☐	_____
COPD / Emphysema	☐	☐	_____
Chronic Bronchitis	☐	☐	_____
Cancer - any organ	☐	☐	_____
Skin			
Eczema	☐	☐	_____
Psoriasis	☐	☐	_____
Ear / Nose / Throat			
Sinus problems	☐	☐	_____
Chronic Allergies	☐	☐	_____
Gastrointestinal	☐	☐	_____
Kidney / Bladder	☐	☐	_____
Bones / Muscles/ Joints	☐	☐	_____
Lymphatic/ Hematological			
Anemia	☐	☐	_____
Bleeding / Clotting	☐	☐	_____
Bones / Muscles / Joints	☐	☐	_____
Other (please describe)	☐	☐	_____
			_____
			_____