MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT CLEARLY

NAME____ TODAYS DATE____

ADDRESS____ HOME PHONE____

____ BIRTHDATE____/____/____AGE_______________________________

EMPLOYER____ STUDENT/GRADE________SCHOOL__________________________

OCCUPATION___________________WORK PHONE______________ HOBBIES____

EMPLOYERS ADDRESS_______________________________________ SPOUSE OR PARENT____

NAME OF MEDICAL DOCTOR________________________________ PATIENT E-MAIL ADDRESS__________________________________

LAST EYE EXAM____/____/____WHERE WERE LAST GLASSES PURCHASED____

REFERRED TO THIS PRACTICE BY___________________________ MEDTHOD OF PAYMENT: C.C.______CHECK_____CASH________

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 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 NO___ YES___

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	____	____	____	______________________________
MS/SARCOIDOSIS/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 DIRECTLY WITH THE DOCTOR IF YOU PREFER.

YES___________, I WOULD PREFER TO DISCUSS MY SOCIAL HISTORY INFORMATION DIRECTLY WITH THE 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, TYPE/AMOUNT/HOW LONG?_________________________
DO YOU DRINK ALCOHOL? 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____ NO_______

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	___	___	___
INTEGUMENTARY (SKIN)	___	___	___
NEUROLOGIAL			
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 INFECT. OF EYE/LID	___	___	___
STIES OR CHALAZION	___	___	___
FLASHES/FLOATERS IN VISION	___	___	___
TIRED EYES	___	___	___
ENDOCRINE			
THYROID/OTHER GLANDS	___	___	___

	NO	YES	?
EAR,NOSE,MOUTH,THROAT			
ALLERGIES/HAY FEVER	___	___	___
SINUS CONGESTION	___	___	___
RUNNY NOSE	___	___	___
POST NASEL DRIP	___	___	___
CHRONIC COUGH	___	___	___
DRY THROAT/MOUTH	___	___	___
RESPIRATORY			
ASTHMA	___	___	___
CHRONIC BRONCHITIS	___	___	___
EMPHYSEMA	___	___	___
VASCULAR/CARDIOVASULAR			
DIABETES	___	___	___
HEART PAIN	___	___	___
HIGH BLOOD PRESSURE	___	___	___
VASCULAR DISEASE	___	___	___
GASTROINTESTINAL			
DIARRHEA	___	___	___
CONSTIPATION	___	___	___
GENITOURINARY			
GENITALS/KIDNEY/BLADDER	___	___	___
BONES/JOINTS/MUSCLES			
RHEUMATOID ARTHRITIS	___	___	___
MUSCLE PAIN	___	___	___
JOINT PAIN	___	___	___
LYMPHATIC/HEMATOLOGIC			
ANEMIA	___	___	___
BLEEDING PROBLEMS	___	___	___
ALLERGIC/IMMUNOLOGIC	___	___	___
PSYCHIATRIC	___	___	___

IF YOU ANSWERED **YES** TO ANY OF THE ABOVE OR HAVE A CONDITION NOT LISTED, PLEASE EXPLAIN & LIST MEDICATIONS:______

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_______________________________ DOCTOR'S SIGNATURE

_______________________________ DATE