

Medical History Questionnaire

Name: _____ Date: _____
Date of Birth: _____
Medical Doctor: _____ Occupation: _____
Doctor's Phone Number: _____
Last Eye Exam: _____

Emergency Contact Person: _____ Telephone Number: _____

Race: White Black/African American Hispanic Asian American Indian Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Pacific Islander

Medical History

List all past major injuries, surgeries, hospitalizations: _____

List all past eye injuries, infections, surgeries, glaucoma, macular degeneration, crossed eyes, droopy eyelid, retinal disease, cataract, lazy eye: _____

***Family* History**

Please check all conditions that apply:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune Disease (lupus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any **drug allergies**: _____

List all **medications you take** (including aspirin, over-the-counter, birth control, herbal remedy etc): _____

Social History *The information is confidential. You may discuss this portion directly with the doctor if you prefer.*

I prefer to discuss my Social History directly with the doctor

Do you Drive? No Yes

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 infected with a sexually transmitted disease? No Yes

Have you ever had a blood transfusion? No Yes

TURN OVER----->>>>

Do you wear glasses? No Yes If yes, how old is your current pair? _____
 Do you wear contact lenses? No Yes If yes, how old is your current pair? _____
 Type of contact lenses: Soft Extended Wear Rigid Other

Are you pregnant/nursing? No Yes

Review of Systems

Do you currently any of the following?

EYES	NO	YES	?	CARDIOVASCULAR	NO	YES	?
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CONSTITUTIONAL			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital/Kidneys/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEAD			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL				Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding (coagulation) disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY				Please Explain: _____			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (SKIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition that is not listed, please explain below:

Patient's Signature

Date