Medical History Questionnaire

Name:____Date:______/______/______

Birth Date:_____/_______/_______ Last Medical Exam: ____/____/____ Last Eye Exam:_____/_____/_____

Name of Primary Care Physician____Physician's Phone:____________________

Medical History

Do you have any allergies to medications? _____No_____Yes If yes, please explain:

____

____

List any medications you take (including oral contraceptives, aspirin, over the counter medication 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 glasses?______________________
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 and/or children, living or deceased) for the following Medical 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			
Sjogrens Syndrome			
Thyroid Disease			
Tuberculosis			
Other			

Social History

Do you drive? ______No ______Yes If Yes, do you have visual difficulty when driving? _____No ______Yes
If yes, Please describe the difficulties you have: ____
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/lhow long? __________________________
Have you ever been exposed to or infected with : _____Gonorrhea ______Syphilis _______HIV ______Hepatitis

Please turn this page and complete side two

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

SYSTEM	NO	YES	EXPLAIN/MEDICATIONS
CONSTITUTIONAL SYMPTOMS			
Fever, Sweats, chills			
Weight Loss			
INTEGUMENTARY (Skin)			
NEUROLOGIC			
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			
Sties or Chalazion			
Flashes/Floaters in Vision			
Tired Eyes			
EARS, NOSE, MOUTH, THROAT			
Allergies			
Hay Fever			
Sinus Congestion			
Runny Nose			
Post-Nasal Drip			
Chronic Cough			
Dry Throat/Mouth			
RESPIRATORY			
Asthma			
Chronic Bronchitis			
Emphysema			
VASCULAR			
Diabetes			
Heart Pain			
High Blood Pressure			
Vascular Disease			
GASTROINTESTINAL			
Diarrhea			
Constipation			
GENITOURINARY			
BONES/JOINTS/ MUSCLES			
Rheumatoid Arthritis			
Muscle Pain			
Joint Pain			
LYMPHATIC/ HEMATOLOGIC			
Anemia			
Bleeding Problems			
ENDOCRINE (Thyroid/ other glands)			
PSYCHIATRIC			

____
Doctor's Signature

____
Review Date