

MEDICAL HISTORY QUESTIONNAIRE

FULL NAME: _____ DATE ____/____/____
 ADDRESS: _____ PHONE: _____
 CITY, STATE ZIPCODE: _____ ALTERNATE PHONE: _____
 BIRTH DATE: ____/____/____ Last 4 of SOCIAL SECURITY #: _____
 SEX: _____ MALE _____ FEMALE E-MAIL _____
 APROXIMATE DATE OF LAST MEDICAL EXAM: ____/____/____ LAST EYE EXAM: ____/____/____
 MEDICAL DOCTOR: _____ PREVIOUS EYE DR. _____
 OCCUPATION: _____ FULL TIME ___ PART TIME ___ RETIRED ___ STUDENT ___
 EMPLOYER/SCHOOL _____
 VISION INSURANCE _____ PRIMARY MEDICAL INSURANCE _____
 HOW DID YOU HEAR ABOUT US? Insurance website Google Facebook Walk By Referral Other _____
 WHO MAY WE THANK FOR REFERRING YOU? _____
INSURED PARTY IF YOU ARE NOT THE PRIMARY, SKIP ANY INFORMATION THAT IS THE SAME
 INSURED NAME: _____ RELATIONSHIP TO PT. _____
 INSURED ADDRESS: _____ PHONE: _____ BIRTH DATE: _____

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

Do you have any environmental allergies, allergies to medications, or latex? ___ YES ___ NO If yes, please list allergen and reaction: _____

Do you wear glasses? _____ If yes, how old is your present pair? _____

Do you wear contacts? _____ If yes, what brand do you wear? _____

Do you use tobacco products? no yes former If yes, what type? How many years? Quit date _____

Do you drink alcohol? Never Rarely Socially Occasionally Weekly Daily

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	Mothers Side			Fathers Side			Other
			Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	
Blindness									
Cataracts									
Crossed Eyes									
Glaucoma									
Macular Degeneration									
Retinal Detachment									
Cancer									
Diabetes Type I or Type II									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Autoimmune Disease									
Thyroid Disease (hyer or hypo)									
Other									

Please list any other pertinent medical information for family members not listed elsewhere: _____

Do you currently or previously have any concerns in the following areas:

	YES	NO	?		YES	NO	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever				Allergies (list below)			
Weight Gain Loss				Sinus Congestion			
INTEGUMENTARY				Runny Nose			
Skin Problems				Post Nasal Drip			
NEUROLOGICAL				Chronic Cough			
Headaches				Dry Throat/Mouth			
Migraines				RESPIRATORY			
Seizures				Asthma			
EYES				Chronic Bronchitis			
Loss of Vision				Emphysema			
Blurred Vision				CARDIOVASCULAR			
Distorted Vision/Halos				Heart Pain			
Loss of Peripheral Vision				High Blood Pressure			
Double Vision				High Cholesterol			
Dryness				Vascular Disease			
Mucus Discharge				GASTROINTESTINAL			
Redness				Diarrhea			
Tired Eyes				Constipation			
Sandy/Gritty Feeling				GENITOURINARY			
Itching				Kidney/Bladder			
Burning				MUSCULARSKELETAL			
Foreign Body Sensation				Rheumatoid Arthritis			
Excess Tearing/Watering				Osteoarthritis			
Glare Light Sensitivity				Muscle/Joint Pain			
Chronic Infection of Eye or Eyelid				LYMPHATIC, HEMATOLOGICAL			
Chronic Sty or Chalazion				Anemia			
Flashes of Light				Bleeding Problems			
Floaters				ENDOCRINE			
Write in Eye Injury, Surgery, or other Condition Not Listed				Thyroid Dysfunction Hyper or Hypo			
AUTO IMMUNE DISEASE (list below)				Diabetes Type I or Type II			
PSYCHIATRIC (list below)				Other Gland Dysfunction (list below)			

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