Medical History Questionnaire

Exam Date _____/_____/________

Last Name ______________________________ First Name _____________________________ M or F Birth Date ____/____/_____

Address ____ City___________________________ State_______ Zip Code___________

Home Phone (____)______________ Work Phone (____)______________ Cell Phone (____)______________ Ok to Text? Y or N

Email Address ____ Preferred Form of Contact: Call Text Email Mail

Primary Care Physician ______________________________ Last Medical Exam ____/____/_____ Height _____ Weight _____

Employer ____________________________ Occupation ____________________________ Social Security # __________________

Referred By _______________________ Last Eye Exam ____/____/_____ By Dr. _______________ Previous Patient? Y or N

Preferred Language: English / Spanish / Other _____________________

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Native Hawaiian / Other Pacific Islander / Other_____________

Race: White / Black or African American / Asian / Hispanic / Native American or Alaskan Native / Middle Eastern / Other

Ocular Symptoms:

Do you currently experience any of the following:

Yes		No	Yes		No
______	Blurred vision	______	______	Foreign body sensation	______
______	Burning	______	______	Glare/light sensitivity	______
______	Chronic infections of eye or lid	______	______	Halos	______
______	Distorted vision	______	______	Itching	______
______	Double vision	______	______	Loss of vision (sudden or temporary)	______
______	Dryness	______	______	Mucous discharge	______
______	Excess tearing /Watering	______	______	Redness	______
______	Eye pain or Soreness	______	______	Sandy or Gritty feeling	______
______	Eyestrain	______	______	Sties or Chalazion	______
______	Flashes of light	______	______	Tired eyes	______
______	Floaters in vision	______			

Ocular History:

Have you had any of the following:

Yes		No
______	Amblyopia/Lazy eye	______
______	Blindness	______
______	Cataracts	______
______	Crossed eyes	______
______	Droopy eyelid	______
______	Eye Injury	______
______	Eye Surgery	______
______	Glaucoma	______
______	Macular degeneration	______
______	Prominent eyes	______
______	Retinal disease	______

Family History:

Do any of your blood relatives (parents, grandparents, siblings, children) have the following:

DISEASE/CONDITION	Yes	No	RELATIONSHIP TO YOU
Blindness	______	______	______________________
Cataract	______	______	______________________
Crossed eyes	______	______	______________________
Glaucoma	______	______	______________________
Macular degeneration	______	______	______________________
Cancer	______	______	______________________
Diabetes	______	______	______________________
Heart disease	______	______	______________________
High blood pressure	______	______	______________________
Lupus	______	______	______________________

Social History:

Do you currently use tobacco products? No / Yes If yes, type/amount/how long: ________________________________

If no, have you smoked in the past? No / Yes If yes, when did you quit? ________________________

Do you drink alcohol? No / Yes If yes, do you drink: Socially Average(1 to 2 servings/day) Above Average Dependent

Do you use illegal drugs? No / Yes If yes, type/amount/how long:____

Have you ever been exposed to or infected with STD's? No/Yes If yes, please list:______________________________

Recreational/Occupational Demands:

Yes		No	Yes		No		
______	Sewing/Needlepoint/Crafting	______	______	Computer Use	______	How many hours/day?	________
______	Reading for Leisure	______	______	Dangerous work environment	______	Need safety Rx?	Yes No
______	Gardening/Home repair	______	______	Musical instruments	______	Which ones?	________________
							________________

Medical History:

Do you have any allergies to medications? No / Yes If yes, please list:______________________________

List any medications you take (include eye drops, oral contraceptives, aspirin, and over the counter/home remedies):

____

____

List all major surgeries, injuries, and hospitalizations:______________________________

Are you pregnant or nursing? No / Yes If yes, for how long?______________________________

Are you being monitored for Diabetes? No / Yes If yes, How when were you were 1st diagnosed?________________

What was your last Hemoglobin A1c? ___________ How well is your Diabetes controlled? Good Fair Poor

What is your average glucose reading? ______________ How often do you check your blood glucose? __________

How is your Diabetes controlled? Diet and exercise Oral medications Insulin Other

If on oral medications, what are they? ______________________________

Spectacle/Contact Lens History:

Do you wear glasses? No / Yes If yes, what type: Single Vision / Progressives / Lined Bifocals / Lined Trifocals / Over-the-counter

If yes, How often do you wear them? ________________________ How old is your present pair of lenses? ______________________

Do you wear contact lenses? No / Yes If yes, type: Rigid/Gas Permeable Soft Extended Wear Daily Disposable

If yes, How often do you wear them? ________________________ How old is your present pair of lenses? ______________________

How often do you replace them? ____________________________ How often do you sleep in them? ____________________________

How many hours per day do you wear them? _______________ How many hours have you had them in today? _____________

My contacts feel dry: After a few hours / At the end of the day / Once they are a few days/weeks old / Rarely / Never

Review of Systems

Allergies: Are you allergic to any foods, medications, or do you have seasonal allergies? No Yes If yes, please list below:

____

Constitutional: Have you had any recent or unexplained fever, weight loss, or weight gain? No Yes ________________________

Have you been followed, treated, or diagnosed with any of the following (circle all that apply):

CARDIOVASCULAR:	Hypertension (High blood pressure)	Myocardial infarction (Heart attack)	Heart disease	High cholesterol	Stroke	Other	None
EAR, NOSE, & THROAT:	Dry mouth	Hearing loss	Sinusitis			Other	None
ENDOCRINE:	Crohn's Disease	Diabetes	Hyperthyroidism	Hypothyroidism	Pituitary disorder	Other	None
GASTROINTESTINAL:	Acid Reflux	Colon Cancer	Hepatitis	Irritable bowel syndrome	Stomach ulcer	Other	None
GENITOURINARY:	Ovarian cyst or tumor	Pelvic inflammatory disease	Prostate Cancer	Uterine Cancer		Other	None
HEMATOLOGIC/LYMPHATIC:	Anemia	Coagulation disorder	Leukemia	Temporal arteritis		Other	None
IMMUNOLOGIC:	Lupus	HIV+ or AIDS	Sarcoidosis	Sjogren's syndrome	Tuberculosis	Other	None
INTEGUMENTARY (SKIN):	Acne rosacea	Albinism	Melanoma or Skin Cancer	Psoriasis	Vitiligo	Other	None
MUSCULOSKELETAL:	Ankylosing spondylitis	Arthritis	Osteoporosis	Rheumatoid arthritis	Scoliosis	Other	None
NEUROLOGIC:	Bell's Palsy	Brain tumor	Epilepsy	Headache or Migraine	Multiple sclerosis	Other	None
PSYCHIATRIC:	Attention disorder	Anxiety	Alzeimer's disease or Dementia	Bipolar disorder	Depression	Other	None
RESPIRATORY:	Asthma	Lung Cancer	COPD	Emphysema	Tuberculosis	Other	None