Medical History Questionnaire

Patient Name: ______________________________ Today's Date: ____________

Date of Birth: ____________ Guardian (If Applicable): ______________________________

Date of Last Eye Exam: ____________ Doctor Name/Location: ______________________________

OCULAR HISTORY

Do you have any **history** of?

	NO	YES
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Cataracts	☐	☐
Retinal Detachment	☐	☐
Retinal disease	☐	☐
Eye Infections	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Iritis	☐	☐
Corneal Disease	☐	☐
Diabetic Retinopathy	☐	☐
Dry Eye Syndrome	☐	☐
Crossed Eyes	☐	☐
Drooping Lids	☐	☐
Prominent eyes	☐	☐
Double Vision	☐	☐
Head Trauma	☐	☐
ANY Eye Surgeries	☐	☐
ANY Eye Injuries	☐	☐

Are you **currently** experiencing?

	NO	YES
General vision change	☐	☐
Sudden blurred vision	☐	☐
Peripheral vision loss	☐	☐
Central vision loss	☐	☐
Mucous Discharge	☐	☐
Distorted vision	☐	☐
Discoloration of eye	☐	☐
Halos or Glare	☐	☐
Redness	☐	☐
Itching	☐	☐
Burning	☐	☐
Light Sensitivity	☐	☐
Sties or Chalazion	☐	☐
Sandy or Gritty feeling	☐	☐
Pain, Soreness, Irritation	☐	☐
Watery Eyes	☐	☐
Dryness	☐	☐
Other: ____________	☐	☐
Other: ____________	☐	☐

Race:

Asian	☐
Native Hawaiian or Other Pacific Islander	☐
Hispanic or Latino	☐
American Indian	☐
Alaska Native	☐
Black or African American	☐
White	☐
Other: ________	☐

If YES to any of the above, please provide details: ______________________________

____

Do you currently wear GLASSES? NO ☐ YES ☐ Age of current lenses: ____________________

Do you wear CONTACT LENSES? NO ☐ YES ☐ ***If yes, please answer the additional questions below:***

Contact Lens Details:

Type of contacts: Soft Monthly Disposable ☐ Soft Daily Disposable ☐ Rigid Gas Permeable (RGP) ☐

Brand: ______________________________ Age of pair (if wearing today): ______________

How often do you replace your contacts? ____________ How often do you sleep in your contacts overnight? ____________

Do you use any eye drops while wearing your contacts? NO ☐ YES ☐ Brand of eye drops: ____________________

Would you like the doctor to update your contact lens prescription today? ________ Do you want to change brands? __________

SOCIAL HISTORY

Do you drive? NO ☐ YES ☐ Do you have difficulty with vision while driving? NO ☐ YES ☐

Hobbies / Activities you tend to do most regularly: ______________________________

Do you *currently* use tobacco products? NO ☐ YES ☐ Circle: Cigarettes/Cigars/Chew Packs/day: ______ How long: ______

Were you a *previous* smoker? NO ☐ YES ☐ If Yes, for how many years ________ When did you quit? __________

Do you drink alcohol? NO ☐ YES ☐ Type: ____________ How often & how long: ______________

Do you use any drugs (legal or illegal)? NO ☐ YES ☐ How often & how long: ______________

Double Sided →

PERSONAL MEDICAL HISTORY

Primary Care Physician & City/State Where Located: ______________________ Last visit: __________

Current Medications:____

____

Vitamins & Supplements: ____

Allergies to Medications: No / Yes If Yes, please list: ______________________________

List surgeries, major injuries, or hospitalizations: ______________________________

____

Height: ______ft _______in. Weight: __________lbs. Are you currently pregnant or nursing? ______________________

Do you **currently have** *or* **have had in the past** any of the following medical conditions?

Endocrine	NO	YES
Diabetes (Type 1)	☐	☐
Diabetes (Type 2)	☐	☐
Thyroid Disease	☐	☐
Thyroid Cancer	☐	☐
Addison's Disease	☐	☐
Cushing's Syndrome	☐	☐
Graves' Disease	☐	☐
Hashimoto's	☐	☐

Musculoskeletal	NO	YES
Osteoarthritis	☐	☐
Joint Pain	☐	☐
Gout	☐	☐
Muscle Pain	☐	☐
Scoliosis	☐	☐

Respiratory	NO	YES
Asthma	☐	☐
Emphysema	☐	☐
Chronic Bronchitis	☐	☐
Sleep Apnea	☐	☐

Immunologic	NO	YES
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
HIV / AIDS	☐	☐

Skin	NO	YES
Psoriasis	☐	☐
Eczema	☐	☐
Shingles	☐	☐
Rosacea	☐	☐

Cardiovascular	NO	YES
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Atrial Fibrillation	☐	☐
Chest Pain	☐	☐
Cholesterol issues	☐	☐

Lymphatic	NO	YES
Lymphedema	☐	☐
Hodgkin's Lymphoma	☐	☐
Non-Hodgkin's Lymph.	☐	☐

Genitourinary	NO	YES
Kidney failure	☐	☐
Endometriosis	☐	☐
Cervical Cancer	☐	☐
Prostate Cancer	☐	☐
Enlarged Prostate	☐	☐
STD: _______________	☐	☐
Chronic UTI		

Blood	NO	YES
Anemia	☐	☐
Leukemia	☐	☐
Bleeding disorder	☐	☐

Other: ________________________

____

____

Gastrointestinal	NO	YES
Diverticulitis	☐	☐
Acid Reflux/GERD	☐	☐
Irrit.Bowel.Synd. (IBS)	☐	☐
Colitis	☐	☐
Colon Polyps	☐	☐
Colon Cancer	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

Psychiatric	NO	YES
Anxiety	☐	☐
Depression	☐	☐
PTSD	☐	☐
Bipolar	☐	☐
Schizophrenia	☐	☐

Neurological	NO	YES
Epilepsy	☐	☐
Parkinson's	☐	☐
Cerebral Palsy	☐	☐
Brain tumor	☐	☐
Bell's Palsy	☐	☐
Migraine	☐	☐
Restless Leg Synd.	☐	☐
Multiple Sclerosis	☐	☐
Traumatic Brain Inj.	☐	☐
Aneurysm	☐	☐
Muscular Dystrophy	☐	☐
ALS	☐	☐
Vertigo/Dizziness	☐	☐
Alzheimer's	☐	☐

FAMILY MEDICAL HISTORY (please list parents, grandparents, siblings, children; living or deceased)

	NO	YES	RELATIONSHIP:
Glaucoma	☐	☐	____________
Cataracts	☐	☐	____________
Macular Degeneration	☐	☐	____________
High Blood Pressure	☐	☐	____________
Diabetes	☐	☐	____________
Blindness	☐	☐	____________

	NO	YES	RELATIONSHIP:
Crossed Eyes	☐	☐	____________
Retinal Detachment	☐	☐	____________
Rheumatoid Arthritis	☐	☐	____________
Lupus	☐	☐	____________
Thyroid Disease	☐	☐	____________
Heart Disease	☐	☐	____________