Medical History Questionnaire

Patient Information

FULL NAME: _____ DATE: ____ / ____ / ____

ADDRESS: _____ PHONE:_____

CITY, STATE ZIPCODE:_____ SEX(circle): Male / Female

DATE OF BIRTH: ____ / ____ / ____ SOCIAL SECURITY #:_____

E-MAIL: _____ LAST EYE EXAM:_____

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS (circle): Phone / E-mail / Text Message

MEDICAL DOCTOR:_____ PREVIOUS EYE DOCTOR:_____

MARITAL STATUS:_____ SPOUSE'S NAME:_____

OCCUPATION:_____ EMPLOYER: _____

VISION INSURANCE:_____ MEDICAL INSURANCE:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?(circle): Insurance / google / website / walk-in / referral / other

WHO MAY WE THANK FOR REFERRING YOU?_____

INSURED PARTY INFORMATION

INSURED NAME: _____ RELATIONSHIP TO PT:_____

INSURED ADDRESS:_____ PHONE:_____ D.O.B:_____

EMPLOYEER: _____ WORK PHONE:_____

EMPLOYEER ADDRESS: _____

MEDICAL HISTORY

Medications: (list all oral and topical medications, vitamins, over the counter medications, aspirin, etc):

_____

_____

Medication allergies?(please list all): _____

Seasonal allergies?: Y / N

List all major injuries, surgeries, and/or hospitalizations:_____

Have you had any of the following? (circle): Crossed eyes Lazy eyes Drooping eyelid Glaucoma Cataract Retinal Disease Macular Degeneration Eye Infection

Do you wear glasses? Y / N If yes, how old is your current pair?_____

Do you wear contacts? Y / N If yes, what type do you wear?_____

SOCIAL HISTORY

Do you drive? Y / N If yes, do you have any visual difficulty when driving? Y / N

Do you use tobacco products? Y / N If yes, what type? Amount? How many years?_____

Do you drink alcohol? Y / N If yes, what type? Amount? How many years?_____

Do you use illegal drugs? Y / N If yes, what type? Amount? How many years?_____

Please turn over and complete other side

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings) of the follow conditions:

DISEASE	NO	YES	RELATION TO YOU
BLINDNESS			
CATARACT			
GLAUCOMA			
MACULAR DEGENERATION			
RETINAL DETACHMENT			
CANCER			
DIABETES			
HEART DISEASE			
HIGH BLOOD PRESSURE			
AUTOIMMUNE DISEASE			
THYROID DISEASE			
OTHER:_____			

REVIEW OF SYSTEMS

Do YOU currently have any problems in the following areas?

SYSTEM	Specific	NO	YES	SYSTEM		NO	YES
CONSTITUTION	Fever, Weight Loss/Gain			EAR/NOSE/THROAT	Allergies		
INTEGUMENTARY (skin)					Sinus Congestion		
NEUROLOGICAL	Headaches				Runny Nose		
	Migraines				Post Nasal Drip		
	Seizures				Chronic Cough		
EYES	Loss of Vision				Dry Mouth		
	Blurred Vision			RESPIRATORY	Asthma		
	Distorted Vision				Chronic Bronchitis		
	Double Vision				Emphysema		
	Dryness			CARDIOVASCULAR	Diabetes		
	Mucous Discharge				Heart Pain		
	Redness				High Blood Pressure		
	Sandy feeling?				Vascular Disease		
	Itching			GASTROINTESTINAL	Diarrhea		
	Burning				Constipation		
	Foreign Sensation			GENITOURINARY	Kidney/Bladder		
	Watering			BONES/JOINTS	Rheumatoid Arthritis		
	Light sensitivity				Osteoarthritis		
	Eye pain				Muscle/Joint Pain		
	Chronic Infection			HEMATOLOGIC	Anemia		
	Stye/Chalazion				Bleed Problems		
	Flashes/Floaters			IMMUNOLOGIC			
	Tired Eyes			PSYCHIATRIC			
ENDOCRINE	Thyroid Dysfunction						
	Other Gland Dysfunction			OTHER (please list)			