Medical History Questionnaire

Name:_____ Date:____/____/____ Birth Date:____/____/____

Last Medical Exam:____/____/____ Name of Medical Doctor:_____ Dr.'s Phone:_____

Name of Pharmacy and Location:_____ Pharmacy Number:_____

Last Eye Exam:____/____/____ Name of Eye Care Provider:_____

Past Eye/Medical History

Allergies: ☐ None ☐ Yes: (list)_____

Have you ever had any eye injuries? ☐ No ☐ Yes: (list)_____

Do you have any eye diseases? Please check all that apply. ☐ Macular Degeneration ☐ Cataract ☐ Glaucoma
☐ Diabetic Retinopathy ☐ Dry Eye Syndrome ☐ Other: (list)_____

Have you ever had any eye surgeries? ☐ No ☐ Yes: (list)_____

Do you currently use any eye medications? ☐ No ☐ Yes: (list)_____

Do you have any medical conditions? Please check all that apply. ☐ Diabetes ☐ High Blood Pressure
☐ Heart Disease ☐ High Cholesterol ☐ Thyroid Disorder ☐ Autoimmune Disease (name:_____)

Please list any additional medical conditions: _____

_____

_____

List all major surgeries (include dates performed):_____

_____

List all medications (include strength and dosing):_____

_____

_____

Are you pregnant or nursing? ☐ No ☐ Yes

Check if you have ever been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis TB

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____

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

Please turn this form over and complete side two*

Social History

Smoking Status: (Check one) ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Never smoked ☐ Smoker, current status unknown ☐ Unknown if ever smoked

If smoker: How much?_____ How long?_____ When quit?_____

Alcohol Use: ☐ No ☐ Yes: Type? _____ How much?_____

Drugs: ☐ No ☐ Yes: Type? _____
How much?_____ How long?_____ When quit?_____

Family History

(Check all that apply to your blood relatives)

	Relationship	Living	Deceased	Approx. Age
☐ Diabetes	_____	☐	☐	_____
☐ Cancer	_____	☐	☐	_____
☐ Heart Disease	_____	☐	☐	_____
☐ High Blood Pressure (Hypertension)	_____	☐	☐	_____
☐ Stroke	_____	☐	☐	_____
☐ Arthritis	_____	☐	☐	_____
☐ TB	_____	☐	☐	_____
☐ Kidney Disease	_____	☐	☐	_____
☐ Blindness	_____	☐	☐	_____
☐ Cataracts	_____	☐	☐	_____
☐ Glaucoma	_____	☐	☐	_____
☐ Macular Degeneration	_____	☐	☐	_____
☐ Retinal Disease	_____	☐	☐	_____
☐ Lazy Eye	_____	☐	☐	_____
☐ Other:_____	_____	☐	☐	_____

Review of Systems

(Please answer yes or no and comment below)

Eyes

Previous Surgery	☐ Yes	☐ No
Contact Lens Use	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Flashes	☐ Yes	☐ No
Floaters	☐ Yes	☐ No

Ear, Nose and Throat

Hard of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No

Constitutional

Fatigue/Weakness	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No
Jaw Pain When Chewing	☐ Yes	☐ No
Scalp Tenderness	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Gastrointestinal

Heartburn	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Jaundice/Hepatitis	☐ Yes	☐ No

Genito-Urinary

Pain/Difficulty Urinating	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
History of Kidney Stones	☐ Yes	☐ No
History of STDs	☐ Yes	☐ No

Psychiatric

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No

Endocrine

Increased Thirst	☐ Yes	☐ No
Increased Hunger	☐ Yes	☐ No
Increased Urination	☐ Yes	☐ No
Increased Sweating	☐ Yes	☐ No
Fingernail Changes	☐ Yes	☐ No

Blood/Lymphnodes

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

MusculoSkeletal

Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint Pain/Swelling	☐ Yes	☐ No

Skin

Rash/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

Neurological

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Immunologic

Hives	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Runny Nose	☐ Yes	☐ No
Sinus Pressure	☐ Yes	☐ No

Explanations:

Doctor's Signature

Review Date