

# Medical History Questionnaire

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Full Name: \_\_\_\_\_

Birth Date: \_\_\_ / \_\_\_ / \_\_\_

Title: Mr. Mrs. Miss Ms. Dr. Other

Marital Status: Single Married Widowed Divorced Separated

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Responsible Party if different: \_\_\_\_\_ Billing Address if different \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If Married, Name of Spouse: \_\_\_\_\_ Spouse's place of work: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Last Medical Exam: \_\_\_ / \_\_\_ / \_\_\_

Name of Previous Eye Doctor: \_\_\_\_\_ Last Eye Exam: \_\_\_ / \_\_\_ / \_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

\*\*\*PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED\*\*\*

A **Fifty Percent (50%)** deposit on all contact lenses and glasses is required before order can be placed. The balance must be paid before materials are dispensed. **We accept Visa, MasterCard, Discover, and Debit Cards**

## Ocular / Medical History

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, what type?  RGP  Soft Do you sleep in them?  No  Yes

How frequently do you replace them? \_\_\_\_\_ Are they comfortable?  Yes  No

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Blurred Vision               | <input type="checkbox"/> Halos                     | <input type="checkbox"/> Redness                                |
| <input type="checkbox"/> Loss of Vision               | <input type="checkbox"/> Glare / Light Sensitivity | <input type="checkbox"/> Excess Tearing / Watering              |
| <input type="checkbox"/> Loss of Side Vision          | <input type="checkbox"/> Dryness                   | <input type="checkbox"/> Eye Pain or Soreness                   |
| <input type="checkbox"/> Distorted Vision             | <input type="checkbox"/> Sandy or Gritty Feeling   | <input type="checkbox"/> Mucous Discharge                       |
| <input type="checkbox"/> Double Vision                | <input type="checkbox"/> Foreign Body Sensation    | <input type="checkbox"/> Chronic Infection of the Eye or Eyelid |
| <input type="checkbox"/> Tired Eyes                   | <input type="checkbox"/> Burning                   | <input type="checkbox"/> Styes or Chalazion                     |
| <input type="checkbox"/> Flashes / Floaters in Vision | <input type="checkbox"/> Itching                   |   |

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Cataracts    | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Lazy Eye             | <input type="checkbox"/> Drooping eyelid    |
| <input type="checkbox"/> Eye Injury   | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other: _____       |

List any **medications** you are currently taking (include oral contraceptives, aspirin, over the counter medications, and home remedies):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you **allergic** to any medications?  No  Yes If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all major **surgeries** and/or **hospitalizations** you have had: \_\_\_\_\_

\_\_\_\_\_

\*\* Please turn this form over and complete side two \*\*

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

RELATION TO YOU		RELATION TO YOU	
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Crossed Eyes	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Retinal Detachment	_____	<input type="checkbox"/> Lupus	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Thyroid Disease	_____

**Review of Systems** Please check the box beside any problem you currently have, or have ever had, in the following areas:

<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/> All Normal	<b>HEMATOLOGIC / LYMPHATIC</b>	<input type="checkbox"/> All Normal
<input type="checkbox"/> Allergy / Hayfever		<input type="checkbox"/> Anemia	
<b>CARDIOVASCULAR / CARDIAC</b>	<input type="checkbox"/> All Normal	<input type="checkbox"/> Bleeding Problems	
<input type="checkbox"/> Arteriosclerosis		<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Heart Disease		<b>INTEGUMENTARY (SKIN)</b>	<input type="checkbox"/> All Normal
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Cancer	
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Rashes	
<b>CONSTITUTIONAL</b>	<input type="checkbox"/> All Normal	<input type="checkbox"/> Easy Bruising	
<input type="checkbox"/> Fever		<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> All Normal
<input type="checkbox"/> Weight Loss / Gain		<input type="checkbox"/> Rheumatoid Arthritis	
<b>EARS, NOSE, MOUTH, THROAT</b>	<input type="checkbox"/> All Normal	<input type="checkbox"/> Muscle Pain	
<input type="checkbox"/> Sinus Congestion		<input type="checkbox"/> Joint Pain	
<input type="checkbox"/> Dry Throat / Mouth		<b>NEUROLOGICAL</b>	<input type="checkbox"/> All Normal
<b>ENDOCRINE</b>	<input type="checkbox"/> All Normal	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Thyroid Disease		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Chronic Fatigue		<input type="checkbox"/> Stroke	
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> All Normal	<b>PSYCHIATRIC</b>	<input type="checkbox"/> All Normal
<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Constipation		<input type="checkbox"/> Depression	
<input type="checkbox"/> Ulcers		<input type="checkbox"/> Memory Loss	
<input type="checkbox"/> Reflux		<input type="checkbox"/> Hallucinations	
<b>GENITOURINARY</b>	<input type="checkbox"/> All Normal	<b>RESPIRATORY</b>	<input type="checkbox"/> All Normal
<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Ovarian / Uterine Cancer		<input type="checkbox"/> Bronchitis	
<input type="checkbox"/> Prostate Cancer		<input type="checkbox"/> Emphysema	
		<input type="checkbox"/> Chronic Cough	

If you checked any of the above boxes or have a condition not listed, please explain further: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you pregnant and / or nursing?  No  Yes

**Social History** This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer. Please check the following box if you wish to discuss your Social History directly with your doctor:

Do you drive?  No  Yes If yes, describe any visual difficulty while driving: \_\_\_\_\_

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

Do you drink alcohol?  No  Yes If yes, type/amount/how long: \_\_\_\_\_

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

Indicate by checking the box if you have been infected with or exposed to:  Gonorrhea  Hepatitis  HIV  Syphilis

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Doctor Use Only: Signature: _____ Date: _____
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