



Medical History Questionnaire

Name: Address: City: State: Zip: Guardian (if applicable): Birth Date: Social Security #: Name of Primary Care Physician: HOW DID YOU HEAR ABOUT US? Drive by Flier Other: What is your preferred method of contact? Phone Text Email

Occupation: Employer: Marital Status: Home/Cell Phone: Work Phone: Email: Last Eye Exam: Last Medical Exam:

Rx History-

Do you wear glasses? Do you wear contact lenses? What type of contact lenses? Do you drive? Do you face the sun when driving to or from work? Do you wear sunglasses?

Chief Complaint- Are you experiencing any of the following:

Blurred Vision Burning Distorted Vision/Halos Double Vision Dryness/Dry Eyes Excess Tearing/ Watering Eye Pain or soreness Flashes/Floaters in Vision Foreign Body Sensation Glare/Light Sensitivity Itching Loss of Side Vision Loss of Vision Mucous Discharge Redness Sandy or Gritty Feeling Tired Eyes Other:

Has there been a change in your vision since your last exam? If yes, explain:

Ocular Conditions- Do you currently have or have you previously been diagnosed with the following conditions:

Cataracts Crossed Eyes Drooping Eyelid Eye Injury Glaucoma Infection of Eye or Lid Lazy Eye Prominent Eyes Retinal Disease Styes or Chalazion Other:

Medical History

Do you have any allergies? Do you have any allergies to medications?

List all medications you take (including oral contraceptives, aspirin, over the counter medications, and herbal supplements):

List all major injuries, surgeries and/or hospitalizations you have had:

Are you pregnant and/or nursing?

Health History

Do you currently, or have you previously had any of the following conditions:

Allergy Yes No

Cardiovascular
Heart Trouble Yes No
High Blood Pressure Yes No

Constitutional
Fever Yes No
Weight Loss Yes No
Weight Gain Yes No

Cranial/Facial
Chronic Cough Yes No
Dry Mouth Yes No
Ear Infection Yes No
Sinus Congestion Yes No

Endocrine
Diabetes Yes No
Thyroid/ Other Glands Yes No

Gastrointestinal
Constipation Yes No
Diarrhea Yes No
Hepatitis Yes No

Genitourinary

Bladder Yes No
Kidney Yes No

Hematologic/Lymphatic
Anemia Yes No
Bleeding Problems Yes No

Immunologic
Syphilis Yes No

Integumentary (Skin) Yes No

Musculoskeletal
Arthritis/Rheumatoid Yes No
Joint Pain Yes No
Muscle Pain Yes No

Neurological
Headaches Yes No
Migraines Yes No
Seizures Yes No

Psychiatric Yes No

Respiratory
Asthma Yes No
Bronchitis Yes No
Emphysema Yes No

Family History

Disease / Condition

Blindness Yes No ?
Cataract Yes No ?
Crossed Eyes Yes No ?
Glaucoma Yes No ?
Macular Degeneration Yes No ?
Retinal Detachment/Disease Yes No ?
Arthritis Yes No ?
Cancer (type: _____) Yes No ?
Diabetes (type: _____) Yes No ?
Heart Disease Yes No ?
High Blood Pressure (Hypertension) Yes No ?
Kidney Disease Yes No ?
Lupus Yes No ?
Thyroid Disease Yes No ?
Other Yes No ?

Relationship to You:

_____ Maternal Paternal
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Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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

Do you use alcohol? Yes No If yes, how often: _____

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

Have you ever been exposed to or infected with HIV? Yes No

PROFESSIONAL FEES ARE DUE UPON COMPLETION OF SERVICES AND ARE NOT REFUNDABLE.

Patient/ Guardian Signature: _____ Date: _____