TODAY'S DATE: _____/_____/_____

Medical History Questionnaire

Name: _____ Home Phone: _____ Preferred Method of Contact: ☐

Address: _____ Cell Phone: _____ Text OK ☐ ☐

City: _____ Zip Code: _____ Work Phone: _____ ☐

Occupation: _____ Employer: _____ E-Mail: _____ ☐

Birth Date: ____/____/_____ Social Security #: _____-_____-_____ Last Eye Exam: ____/____/_____

DEMOGRAPHICS

If Minor, Parent/Guardian name: _____ SSN: _____ DOB: _____ Employer: _____

Vision Insurance Carrier: _____ Subscriber Name: _____ Contract #: _____

Medical Insurance Carrier: _____ Subscriber Name: _____ Contract #: _____

How did you hear about us? Family or friend? _____ Yellow Pages? _____ Other? _____

Vitals: Height: _____ ***Weight:*** _____

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Pacific Islander/Native Islander ☐ Other ☐ Decline to Specify

PERSONAL MEDICAL/EYE HISTORY

- List all medications you are currently taking (prescription and over-the-counter). _____
- Do you have any allergies to medications? ☐ Yes ☐ No If yes, please explain _____

Please note if you have any of the following conditions.

☐ None	☐ Diabetes	☐ High Cholesterol	☐ Macular Degeneration
	☐ Cancer	☐ Arthritis	☐ Eye Injury
	☐ Heart Disease	☐ Glaucoma	☐ Strabismus/Amblyopia
	☐ High Blood Pressure	☐ Cataracts	☐ Other _____

- List major injuries and surgeries you have had. _____
- Date of your last physical exam _____ Are you pregnant / nursing? ☐ Yes ☐ No
- Name and phone number of your medical doctor(s): _____
- Have you had your eyes dilated? ☐ Yes ☐ No If yes, were there any problems? _____
- Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? _____
- Have you ever worn contact lenses? ☐ Yes ☐ No Do you now wear contact lenses? ☐ Yes ☐ No
- Are you planning to get new glasses or contact lenses today? ☐ Yes ☐ No ☐ Maybe

FAMILY MEDICAL/EYE HISTORY

Please note any family members with the following conditions. Please also note on the line next to the condition how that person is related to you.

☐ None	☐ Diabetes _____	☐ High Cholesterol _____	☐ Macular Degeneration _____
	☐ Cancer _____	☐ Arthritis _____	☐ Retinal disease _____
	☐ Heart Disease _____	☐ Glaucoma _____	☐ Strabismus/Amblyopia _____
	☐ High Blood Pressure _____	☐ Cataracts _____	☐ Other _____

PERSONAL SOCIAL HISTORY

- Does your occupation or any hobbies/recreational activities require the use of safety eyewear? ☐ Yes ☐ No
- Do you use an electronic device at work/home? ☐ Yes ☐ No If yes, how many hours/day? _____
- Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No If yes, what type/amount/how long? _____
- Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____
- Do you use illegal drugs? ☐ Yes ☐ No If yes, how often? _____
- Have you ever been infected with the following: HIV? ☐ Yes ☐ No TB? ☐ Yes ☐ No Hepatitis? ☐ Yes ☐ No

****Please turn this form over and complete side 2****

REVIEW OF SYSTEMS

Please indicate below **if you currently have or have in the last month,** had any of the following health signs and symptoms:

Eyes

☐ None	☐ Blurred vision	☐ Burning	☐ Eye injury	☐ Light sensitivity/glare
	☐ Loss of vision	☐ Dryness	☐ Eye pain	☐ Eye turn
	☐ Redness	☐ Excessive tears	☐ Flashes/floaters	☐ Double vision
	☐ Itching	☐ Tired/sore eyes	☐ Vision disturbance	☐ Other_____

Constitutional

☐ None	☐ Fever	☐ Weight loss	☐ Chills	☐ Other_____

Ears, Nose, Mouth, Throat

☐ None	☐ Hearing loss	☐ Sinus congestion	☐ Sore throat	☐ Other_____

Respiratory

☐ None	☐ Shortness of breath	☐ Pain when breathing	☐ Chronic cough	☐ Other_____

Cardiovascular

☐ None	☐ Chest pain	☐ Palpitations	☐ Lightheaded	☐ Other_____

Gastrointestinal

☐ None	☐ Nausea	☐ Constipation	☐ Diarrhea	☐ Other_____

Genitourinary

☐ None	☐ Increased frequency	☐ Increased urgency	☐ Burning/itching	☐ Other_____

Muscles/Bones/Joints

☐ None	☐ Joint pain	☐ Joint swelling	☐ Restricted motion	☐ Other_____

Endocrine

☐ None	☐ Frequent urination	☐ Elevated blood sugar	☐ Excessive thirst	☐ Other_____

Psychiatric

☐ None	☐ Anxiety	☐ Depression	☐ Insomnia	☐ Other_____

Blood/Lymph

☐ None	☐ Bleeding disorder	☐ Swollen lymph nodes	☐ Low blood count	☐ Other_____

Allergic/Immunologic

☐ None	☐ Seasonal allergies	☐ Suppressed immune system	☐ Allergic rhinitis	☐ Other_____

Skin

☐ None	☐ Rashes	☐ Rosacea	☐ Growths	☐ Other_____

Neurological

☐ None	☐ Headaches	☐ Slurred speech	☐ Dizziness	☐ Other_____

Please explain any of the signs and symptoms that you checked above:

_____

_____

_____

_____

Patient Signature _____ **Date** _____