

# Medical History Questionnaire

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

Name: \_\_\_\_\_ Home/Cell phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Employer: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_  
Referred by? \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Email address: \_\_\_\_\_

## Eyes

Please check any of the following that pertain to you:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Blurry vision  | <input type="checkbox"/> Missing areas         | <input type="checkbox"/> Halos/distortion | <input type="checkbox"/> Double vision  |
| <input type="checkbox"/> Dryness/gritty | <input type="checkbox"/> Redness               | <input type="checkbox"/> Itching/burning  | <input type="checkbox"/> Styes          |
| <input type="checkbox"/> Glare          | <input type="checkbox"/> Flashes/floaters      | <input type="checkbox"/> Foreign body     | <input type="checkbox"/> Excess tearing |
| <input type="checkbox"/> Pain           | <input type="checkbox"/> Need/Want new glasses |   |   |

If you checked any of the above, please explain what, when did it start, which eye, for how long, does anything make it worse or better and any information that may help us to help alleviate your symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medical History

Allergies to medicines: Yes or No If yes, please specify \_\_\_\_\_

List all medications you currently take (include birth control, aspirin, over the counter and home remedy, vitamins) or circle NONE if you don't take any meds. If you have a list, we can photocopy it for you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do **YOU** have: **(Circle any that apply)** crossed eyes, lazy eye, droopy eyelid, Glaucoma, Macular Degeneration, Cataracts

If you are female, are you pregnant or nursing: (Circle) Yes or No

Do you wear glasses? (Yes or No) Do you wear contacts? (Circle) Yes or No

If you are a new patient and wear contacts, what is the brand and power? \_\_\_\_\_

Would you like to try contacts? (Circle) Yes or No

**Please continue on back**

**Family History**

Check any that apply to your grandparents, parents, siblings or offspring:

- Cataract     Glaucoma     Thyroid     Macular Degeneration     Hypertension
- Cancer     Crossed Eyes     Lupus     Heart Disease     Kidney Disease
- Diabetes     Arthritis     Retinal Detachment

If you checked any of the above, please specify their relationship to you:

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**Social History**

Circle any of the following that pertain to you: alcohol, tobacco, illicit drug use?

**Review of Systems**

Please check any of the following that pertain to YOU:

- Diabetes I / II     Thyroid     Allergies     Headache
- Weight loss/gain or fever     Cancer     Heart disease     Hypertension
- Stroke     Cholesterol     GERDS     Prostate
- Anemia     Osteoporosis     Arthritis     Joint Replacement
- MS     Parkinson's     Asthma     COPD
- Eczema     Rosacea     Hearing loss     Dry mouth

If you checked any above, please specify what, how long, if you're under any treatment:

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By signing below, you agree the above information is correct.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only**

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

At each subsequent visit, please review for any changes, sign and date. If there are any changes, **please initial and date** the place where you made the change:

Reviewed by: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Reviewed by: \_\_\_\_\_