Medical History Questionnaire

Date: ___________

Name: ______________________________ Home/Cell phone: _________________________
Address: ____________________________ Work Phone: _______________________________
City: _______________________________ Employer: ________________________________
Birth Date: _________________________ Primary Care Doctor: ______________________

Referred by? __________________________ Social Security #: ________________________
Email address: ___________________________

Eye History

Please check any of the following that pertain to you:

☐ Blurry vision ☐ Missing areas ☐ Halos/distortion ☐ Double vision
☐ Dryness/gritty ☐ Redness ☐ Itching/burning ☐ Styes
☐ Glare ☐ Flashes/floaters ☐ Foreign body ☐ Excess tearing
☐ Pain ☐ Droopy Lid ☐ Glaucoma ☐ Cataracts
☐ Crossed Eyes ☐ Macular Degeneration

If you checked any of the above, please report when it started, which eye, for how long, does anything make it worse or better, and any information that may help us to help alleviate your symptoms:____
____
____

Do you wear glasses? (Yes or No) If yes, do you want new 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

Medical History

List all medications you currently take (include birth control, aspirin, over the counter, home remedy, and vitamins) or circle NONE if you don't take any meds. If you have a list, we can photocopy it for you: ____
____
____
Allergies to medicines: Yes or No. If yes, please specify: _________________________
____

Continue on back

Family History

Check and specify who, in your immediate family, has any of the following:

☐ Cataract________ ☐ Glaucoma____________ ☐ Thyroid____________

☐ Macular Degeneration_________ ☐ Hypertension_________

☐ Cancer________ ☐ Crossed Eyes________ ☐ Lupus_______________

☐ Heart Disease__________ ☐ Kidney Disease___________ ☐ Diabetes_________

☐ Arthritis_______________ ☐ Retinal Detachment ______________

Social History

Check 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

☐ Pregnant or nursing (if female)

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

____

____

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: _____________________________