Medical History Questionnaire

Name ______________________________ Today's Date ____________________

Address ______________________________ Hm. Phone ____________________

City, ST, Zip ______________________________ Wk. Phone ____________________

Date of Birth ____________ Email ____________________ Cell phone ____________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Employer ____________________
Employment: ☐FT ☐PT ☐Student ☐Retired ☐Active Military Occupation ____________________

Last Eye Exam ____________ Patient Gender ☐M ☐F Driv. License #____________________

Vision Care Insurance Co. ______________________________ Social Sec. # ____________________
Medical Insurance Co. ______________________________ ID # ____________________
Name of Primary Care Physician:______________________________ Phone # ____________________

Are you pregnant or nursing? ☐ no ☐ yes Height /Weight: ____ft_____in/ ________lbs
Have you ever worn Contacts? ☐ no ☐ yes
If yes, type of contacts:______________________ Do you want to continue with this type? _____
If no, Are you interested in wearing contacts? ________

Medical History

Condition	No	Yes
Arthritis	☐	☐
Cancer	☐	☐
Cholesterol Elevated	☐	☐
Crohn's Disease	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Lupus	☐	☐
Migraines	☐	☐
Meningitis	☐	☐
Thyroid Disease	☐	☐
Other:______________________		
Past Surgeries		
Heart	☐	☐
Brain	☐	☐
Gastrointestinal		
Other: ______________________		

Ocular History

Condition	No	Yes
Allergies	☐	☐
Abrasion	☐	☐
Amblyopia	☐	☐
Blindness	☐	☐
Cataract	☐	☐
Dry Eye Syndrome	☐	☐
Diplopia (double vision)	☐	☐
Retinal Detach/disease	☐	☐
Floaters	☐	☐
Lazy Eye	☐	☐
Macular Degeneration	☐	☐
Other:______________________		
Past Ocular Surgeries		
Strabismus (Lazy eye)	☐	☐
Cataract	☐	☐
LASIK/PRK	☐	☐
other:______________________		

Medications : (include oral contraceptives, aspirin, OTC medications and home remedies)
Systemic: (for your body)

____

____

Ocular:____

Are you allergic to any medications? ☐ no ☐ yes If yes, list them: ______________________

____

Family History

Please note any **family members** (living or deceased) for the following conditions:

Condition	No	Yes	Relationship
Blindness	☐	☐	______________________
Glaucoma	☐	☐	______________________
Macular Degeneration	☐	☐	______________________
Retinal Disease	☐	☐	______________________
Cancer	☐	☐	______________________
Diabetes	☐	☐	______________________
Heart Disease	☐	☐	______________________
High Blood Pressure	☐	☐	______________________
Thyroid Disease	☐	☐	______________________

Social History *This information is kept strictly confidential.*

☐ I would like to discuss this section with the doctor only

Do you smoke? ☐ no ☐ yes If **yes** packs/day: _________________

Do you drink alcohol? ☐ no ☐ yes If **yes** drinks/day: _________________

Do you use illegal drugs? ☐ no ☐ yes If **yes** amount/type: _______________

Have you ever been exposed to or infected with ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Have you **currently** had any problems in the following areas:

SYSTEM	NO	YES
Constitutional		
Fever	☐	☐
Weight Loss/Gain	☐	☐
Integumentary		
Skin	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Endocrine		
Thyroid / Other Glands	☐	☐
Diabetes	☐	☐
Allergy	☐	☐
Psychiatric	☐	☐
Head (Ear, Nose, Mouth, Throat)		
Sinus Congestion	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat / Mouth	☐	☐

	NO	YES
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Cardiovascular		
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary		
Genitals/Kidney/Bladder	☐	☐
Musculoskeletal: (Bones/Joints/Muscles)		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐

If you answered YES to any of the above, please explain: ____________________________________

____

Patient Signature:____Date:______________

If Patient is minor or unable, Parent/caretaker signature: __________________________Date:______________

If Nursing staff completed, sign here: ____Date:______________