



# Medical History Questionnaire

Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Check One:      Dr.    Mr.    Mrs.    Ms.    Miss    Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Name on Soc. Sec. Card (If different): \_\_\_\_\_ e-mail address \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_ Date of Last Medical Exam: \_\_\_\_\_

Do you have Medical Insurance?    YES    NO    Do you wear glasses?    YES    NO    Do you wear contacts?    YES    NO

## **Medical History**

Do you have any allergies to medications?    No    Yes

If "Yes", explain \_\_\_\_\_

List any medications you are currently taking (including oral contraceptives, aspirin, over-the-counter medications, prenatal vitamins and home remedies).

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

Mark any of the following that you have ever had:

Crossed eyes	Drooping eyelid	Prominent eyes	Retinal disease	Eye Infections
Lazy eye	Glaucoma	Cataracts	Iritis	Eye Injury

Explain: \_\_\_\_\_

## **Family History**

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

<b>DISEASE/CONDITION</b>	<b>NO</b>	<b>YES</b>	<b>?</b>	<b>RELATIONSHIP TO YOU</b>
Blindness				
Cataracts				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease				
Other				

**Social History** *This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.*  
 Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive?    No    Yes    If yes, do you have visual difficulty when driving?    No    Yes    If yes, please describe:

Do you use tobacco products?    No    Yes    If "Yes", describe type/amount/how long:

Do you drink alcohol?    No    Yes    If "Yes", describe type/amount/how long:

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

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

**Review of Symptoms**

Do you currently, or have you ever had any problems in the following areas?

	<b>NO</b>	<b>YES</b>	<b>?</b>	<b>EARS, NOSE, MOUTH, THROAT</b>	<b>NO</b>	<b>YES</b>	<b>?</b>
<b>CONSTITUTIONAL</b>							
Fever, Weight Loss/Gain				Allergies/Hay Fever			
<b>INTEGUMENTARY (Skin)</b>				Sinus Congestion			
<b>NEUROLOGICAL</b>				Runny Nose			
Headaches				Post-Nasal Drip			
Migraines				Chronic Cough			
Seizures				Dry Throat/Mouth			
<b>EYES</b>				<b>RESPIRATORY</b>			
Loss of Vision				Asthma			
Blurred Vision				Chronic Bronchitis			
Distorted Vision/Halos				Emphysema			
Loss of Side Vision				<b>VASCULAR / CARDIOVASCULAR</b>			
Double Vision				Diabetes			
Dryness				Heart Pain			
Mucous Discharge				High Blood Pressure			
Redness				Vascular Disease			
Sandy or Gritty Feeling				<b>GASTROINTESTINAL</b>			
Itching				Diarrhea			
Burning				Constipation			
Foreign Body Sensation				<b>GENTOURINARY</b>			
Excess Tearing/Watering				Genitals / Kidney / Bladder			
Glare/Light Sensitivity				<b>BONES / JOINTS / MUSCLES</b>			
Eye Pain or Soreness				Rheumatoid Arthritis			
Chronic Infection of Eye or Lid				Muscle Pain			
Styes or Chalazion				Joint Pain			
Flashes/Floaters in Vision				<b>LYMPHATIC / HEMATOLOGIC</b>			
Tired Eyes				Anemia			
<b>ENDOCRINE</b>				Bleeding Problems			
Thyroid/Other Glands				<b>ALLERGIC / IMMUNOLOGIC</b>			
				<b>PSYCHIATRIC</b>			

If you answered "YES" to any of the above or have a condition not listed, please explain and list medications:

\_\_\_\_\_  
Physicians Signature

\_\_\_\_\_  
Date