Medical History Questionnaire

The information in this CONFIDENTIAL case history form is critical to the evaluation of your vision and health.

Name:_____D.O.B._____Today's Date _____ / _____ / _____

Patient Medical Historv

Name of Family Physician_____
Date of Last Physical Check-up_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Do you have any drug allergies? ☐ Yes ☐ No
_____

Are you pregnant or nursing? ☐ Yes ☐ No
Have you had <u>any</u> surgeries? ☐ Yes ☐ No
_____

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____
Have you ever experienced, been diagnosed or treated for any of the following?

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Eye Infections
- ☐ Flashes of light
- ☐ Lazy Eye/ Turned eye
- ☐ Corneal Abrasions
- ☐ Iritis/Uveitis
- ☐ Eye Injury
- ☐ Retinal Detachment
- ☐ Glaucoma

<u>Answer the questions below only if you currently wear contact lenses:</u>

What type or brand of contacts do you wear? _____

1. How old are your current lenses? _____
2. How often do you replace or dispose of your contact lenses?_____
3. What brand of solution do your lenses soak in overnight? _____
4. What is your typical wearing schedule? _____Hours/ Day_____Days/Week
5. Are you having any problems with your current contact lenses? ☐ Yes ☐ No

Family History

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

DISEASE/ CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Disease/Detachment	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other_____				

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

Social History

Many diseases of the body have grave eye health consequeces, and vice versa! Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Do you drive? ☐ yes ☐ no If yes, do you have visual difficulty when driving? ☐ yes ☐ no

Do you use tobacco products? ☐ no ☐ occasionally ☐ pack/day ☐ 1 pack/day ☐ 1+ pack/day

Do you drink alcohol? ☐ no ☐ occasionally ☐ 1/day ☐ 2-3/day ☐ 4+/day

Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Review of Systems

Do you currently, or have you ever had any **PROBLEMS** in the following areas:

SYSTEM	Yes	No
CONSTITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
***With vision correction being used**, do you suffer from the following?*		
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

	Yes	No
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR / CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain/ Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

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

_____

_____

_____ _____

Patient's signature Date

_____ _____

Doctor's Signature Date