Patient Medical History Questionnaire

Today's date: ____ / ____ / ____ If you are a new patient, when was your last exam: ____ / ____ / _____

Name: ________________________________ Birthdate: ____ / ____ / ____ SS#: ____________________

Address: ______________________________ Phone: ____

______________________________________ Cell Phone: _____________________________________

Employer: _____________________________ Occupation: ____________________________________

Your Email Address: _________________________________ Preferred method of communication: email, phone, postal

Spouse's Name (if applicable): ____

Emergency Contact Name: ______________________________ Emergency Contact Phone: _____________________

Medical Doctor: ________________________________ Last Medical Exam: __________________________________

If you are a new patient, how did you hear about our office? (family, friend, phonebook, etc.): ______________________

Medical History

Allergies? Yes ☐ No ☐ If yes, please list: ____

List any current medications: ____

____

Circle any of the following that you have or have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury, or head injury:______________________

List any major surgeries, injuries, and/or hospitalizations: ____

If applicable, are you pregnant or nursing? Yes ☐ No ☐

If you are a new patient, do you wear glasses? Yes ☐ No ☐ Contact Lenses? Yes ☐ No ☐

Brand of contacts: _________________ Prescription, if known: Right_________________ Left______________________

Family History

Please note any family history (parents, maternal or paternal grandparents, siblings) for the following conditions:

Disease/Condition	YES	NO	?	Relationship to you
Amblyopia (lazy eye)	☐	☐	☐	
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular degeneration	☐	☐	☐	
Retinal detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other: ____________	☐	☐	☐	

Please turn this form over and complete side two

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

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

If yes, describe: ______________________________

Do you use tobacco products? Yes ☐ No ☐ If yes, type/amount/how long? ______________

Have you ever smoked? Yes ☐ No ☐ If yes, when did you quit? ______________

Do you drink alcohol? Yes ☐ No ☐ If yes, type/amount/how long? ______________

Do you use illegal drugs? Yes ☐ No ☐ If yes, type/amount/how long? ______________

Have you ever been exposed to or infected with? ☐ No ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems Are you currently experiencing any problems in the following areas:

	YES	NO	?
CONSTITUTIONAL			
Fever, weight loss/gain	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Haloes	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy/Gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body sensation	☐	☐	☐
Excess tearing/Watering	☐	☐	☐
Tired eyes	☐	☐	☐
Glare/Light sensitivity	☐	☐	☐
Eye Pain or soreness	☐	☐	☐
Chronic infection of Eye/Lid	☐	☐	☐
Sties or chalazion	☐	☐	☐
Flashes/Floaters in vision	☐	☐	☐
ENDOCRINE			
Diabetes	☐	☐	☐
Thyroid/Other glands	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

	YES	NO	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay fever	☐	☐	☐
Ear infections	☐	☐	☐
Sinus Disease	☐	☐	☐
Hearing Loss	☐	☐	☐
Dental Disorder	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
COPD	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
GASTROINTESTINAL			
Chronic Diarrhea	☐	☐	☐
Stomach/Intestinal Disease	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BLOOD/JOINTS/MUSCLES			
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Blood Disease	☐	☐	☐

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

____

____

Are you interested in:

<u>New Eyewear</u> Yes ☐ No ☐ <u>New Lenses</u> Yes ☐ No ☐ <u>Sunglasses</u> Yes ☐ No ☐ <u>Contacts Lenses</u>: Yes ☐ No ☐

Patient's Signature: ______________________ Date: ______________

Doctor's Signature: ______________________ Date: ______________