Medical History Questionnaire

Please fill out BOTH sides of the page

Today's Date ___/___/_____

Full Name _____ Gender □ Male □ Female

DOB ___/___/_____ SSN _____ Email: _____

Address _____ *Please provide an email so that we may

City/State _____ Zip _____ confirm your appointments electronically

Primary Phone: _____ Home/Cell/Work Occupation _____

Secondary Phone: _____ Home/Cell/Work Employer _____

May we text to confirm your appointments? □ Yes □ No

Emergency Contact: Name _____ Relationship _____ Phone _____

How did you hear about us? □ Google □ Facebook/Instagram □ Insurance List

□ The Reminder □ Doctor Referral (Name: _____)

□ Friend/Family (Name: _____) □ Other _____

Primary Physician Name & Address _____

Medical Insurance _____ Vision Insurance _____

Patient History

Do you experience any of the following? (please check all that apply)

□ Blurred Vision	□ Loss of Vision	□ Double Vision	□ Distorted Vision/Halos
□ Light Sensitivity	□ Floaters/Spots	□ Flashes of Light	□ Eye Strain
□ Dry Eyes	□ Itching/Burning	□ Tearing/Watering	□ Sandy/Gritty Feeling
□ Eye Redness	□ Eye Discharge	□ Eye Pain	□ Other _____

Last Eye Exam Date _____ Doctor Name/Office _____

Do you currently wear glasses? □ Y □ N If yes, how old is your current pair? _____

Do you currently wear contact lenses? □ Y □ N If yes, how old is your current pair? _____

Type of contact lenses: □ Rigid □ Soft □ Overnight/Extended □ Other

Are you happy with the comfort of your current contact lenses? □ Yes □ No

How many hours a day do you use digital devices (ie. Computer, tablet, cell phone)? _____

Any history of injuries or surgeries to your eyes? _____

List all medications currently taken (including oral contraceptives, eye drops, and over-the-counter)

_____

_____

_____

Do you have any allergies to medications? □ Yes □ No If Yes, list: _____

_____

_____

Medical History Questionnaire

Please fill out BOTH sides of the page

Do you, or any of your relatives (living or deceased) have any of the following:

Disease/Condition	Yes	Unsure	If Yes: Self	or	List Family Member
Blindness	□	□	□		_____
Cataracts	□	□	□		_____
Crossed/Lazy Eyes	□	□	□		_____
Glaucoma	□	□	□		_____
Macular Degeneration	□	□	□		_____
Retinal Detachment	□	□	□		_____
Retinal Disease	□	□	□		_____
Arthritis	□	□	□		_____
Cancer	□	□	□		_____
Diabetes	□	□	□		_____
Heart Disease	□	□	□		_____
High Blood Pressure	□	□	□		_____
High Cholesterol	□	□	□		_____
Kidney Disease	□	□	□		_____
Lupus	□	□	□		_____
Thyroid Disease	□	□	□		_____
Other _____	□	□	□		_____

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

Are you currently pregnant and/or nursing? □ Yes □ No

Do you drive? □ Yes □ No If Yes, do you have any visual difficulty driving? □ Yes □ No

Tobacco History: □ Current Smoker □ Former Smoker □ Never a Smoker

Alcohol Use: □ Yes □ No If Yes, amount: _____

Recreational Drug Use: □ Yes □ No If Yes, □ Currently □ Previously Type: _____

Have you ever been exposed to, or infected with □ Hepatitis □ HIV □ Syphilis

What are your hobbies? Please tell us if you have any specific activities that require precise visual needs.

_____

Review of Systems Please check any problems you currently have for the following areas:

ALLERGIC/IMMUNOLOGIC
□ Seasonal Allergies

CARDIOVASCULAR
□ History of Heart Attack
□ History of Stroke

CONSTITUTIONAL
□ Fever
□ Weight Loss/Gain
□ Fatigue

EARS, NOSE, THROAT
□ Allergies/Hay Fever
□ Sinus Congestion
□ Dry Mouth/Throat

ENDOCRINE
□ Type 1 Diabetes
□ Type 2 Diabetes
□ Hormonal Dysfunction

GASTROINTESTINAL
□ Colitis
□ Crohn's Disease

GENITOURINARY
□ Prostate Disease
□ STD

HEMATOLOGIC
□ Anemia
□ Bleeding Disorder

INTEGUMENTARY/SKIN
□ Eczema
□ Rosacea
□ Psoriasis

LYMPHATIC
□ Leukemia

MUSCULOSKELETAL
□ Rheumatoid Arthritis
□ Ankylosing Spondylitis

NEUROLOGICAL
□ Headaches/Migraines
□ Seizures
□ Multiple Sclerosis

PSYCHIATRIC
□ ADD/ADHD
□ Alzheimers/Dementia
□ Anxiety/Depression

RESPIRATORY
□ Asthma
□ COPD
□ Emphysema
□ Sarcoidosis

OTHER
□ _____
□ _____
□ _____

_____ _____

Patient/Guardian Signature **Date**