MEDICAL HISTORY QUESTIONNAIRE

FULL NAME: _____ DATE_____/_____/_____
ADDRESS: _____PHONE: _____
CITY, STATE, ZIPCODE:_____ALTERNATE PHONE: _____
BIRTH DATE: _____/_____/_____ Last 4 of SOCIAL SECURITY #: _____
SEX: _____MALE _____FEMALE E-MAIL_____
APROXIMATE DATE OF LAST MEDICAL EXAM: _____/_____ LAST EYE EXAM: _____/_____
MEDICAL DOCTOR:_____ PREVIOUS EYE DR._____
OCCUPATION:_____FULL TIME___PART TIME___RETIRED ___STUDENT ___
EMPLOYER/SCHOOL_____
VISION INSURANCE_____PRIMARY MEDICAL INSURANCE_____
VISION INS ID #_____ MEDICAL INS ID #_____
HOW DID YOU HEAR ABOUT US? Insurance website Google Facebook Walk In Referral Other_____
*WHO MAY WE THANK FOR REFERRING YOU?*_____
INSURED PARTY IF YOU ARE NOT THE PRIMARY, SKIP ANY INFORMATION THAT IS THE SAME
INSURED NAME: _____ RELATIONSHIP TO PT._____
INSURED ADDRESS: _____ PHONE:_____ BIRTH DATE:_____
INSURED ID # _____ GROUP #_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):
_____
Do you have any environmental allergies, allergies to medications, or latex? ___YES___NO If yes, please list allergen and reaction: _____
_____
Do you wear glasses? _____ If yes, how old is your present pair?_____
Do you wear contacts? _____ If yes, what brand do you wear?_____
Do you use tobacco products? □ no □ yes □ former: If yes, what type? How many years? Or quit date _____
Do you drink alcohol? Never Rarely Socially Occasionally Weekly Daily

FAMILY HISTORY

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

			Mothers Side			Fathers Side			
Disease/Condition	No	Yes	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Other
Blindness									
Cataracts									
Crossed Eyes									
Glaucoma									
Macular Degeneration									
Retinal Detachment									
Cancer									
Diabetes (circle type) **Type I or Type II**									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Autoimmune Disease									
Thyroid Disease (circle)**Hyper or Hypo**									
Other									

Please list any other pertinent medical information for family members not listed elsewhere:_____
_____

Do you currently have or previously have had any concerns in the following areas:

	YES	NO	?		YES	NO	?
CONSTITUTIONAL				**EARS, NOSE, MOUTH, THROAT**			
Fever				Allergies (list below)			
Weight Gain Loss				Sinus Congestion			
INTEGUMENTARY				Runny Nose			
Skin Problems				Post Nasal Drip			
NEUROLOGICAL				Chronic Cough			
Headaches				Dry Throat/Mouth			
Migraines				**RESPIRATORY**			
Seizures				Asthma			
EYES				Chronic Bronchitis			
Loss of Vision				Emphysema			
Blurred Vision				**CARDIOVASCULAR**			
Distorted Vision/Halos				Heart Pain			
Loss of Peripheral Vision				High Blood Pressure			
Double Vision				High Cholesterol			
Dryness				Vascular Disease			
Mucus Discharge				**GASTROINTESTINAL**			
Redness				Diarrhea			
Tired Eyes				Constipation			
Sandy/Gritty Feeling				**GENITOURINARY**			
Itching				Kidney/Bladder			
Burning				**MUSCULOSKELETAL**			
Foreign Body Sensation				Rheumatoid Arthritis			
Excess Tearing/Watering				Osteoarthritis			
Glare Light Sensitivity				Muscle/Joint Pain			
Chronic Infection of Eye or Eyelid				**LYMPHATIC, HEMATOLOGICAL**			
Stye or Chalazion				Anemia			
Flashes of Light				Bleeding Problems			
Floaters				**ENDOCRINE**			
Write in Eye Injury, Surgery, or other Condition Not Listed				Thyroid Dysfunction Hyper or Hypo			
AUTO IMMUNE DISEASE (list below)				Diabetes Type I or Type II			
PSYCHIATRIC (list below)				Other Gland Dysfunction (list below)			

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

_____

_____

_____

_____