Medical History Questionnaire

Name: _____ Date: ____/____/____ Family Physician: _____

Do you *currently* have any problems in the following areas? If "YES", provide information:

Present Illness	*Yes*	*No*	*Explanation, Date Diagnosed, & Treatment.*
Vision Complaints (Decreased Vision, Eye Strain)			
Vision Symptoms (Double Vision, Blurry Vision)			
Vision Loss (Macular Degeneration, Diabetic Retinopathy, Glaucoma)			
Allergy Eye			
Ocular Symptoms (Itching, Dry Eyes, Watery, Burning, Eye Infection, Iritis, Mucous Discharge, Eyelid Disease, Glare)			
Red Eye			
Eye Pain			
Floaters/Flashes			
Eye Turn			
Headaches			
Systemic Symptoms			

Have you *ever* been diagnosed with the following conditions? If "YES" provide information:

Condition	*Yes*	*No*	*Explanation, Date Diagnosed, & Treatment.*
Allergy (Seasonal, Food, Drug)			
Cardiovascular (Heart Disease, Cholesterol, Hypertension, Diabetes)			
Constitutional (Fever, Weight Loss, etc.)			
Endocrine (Hypothyroid, Gout, etc.)			
Gastrointestinal (Gall Bladder, Stomach Ulcers, Intestinal Disease, etc.)			
Genitourinary (Bladder Infections, Ovarian Cyst, Kidney Stones)			
Head (Ears, Nose, Throat, Sinus, Ear Infection, Chronic Cough)			
Hematologic/Lymphatic (Anemia, Leukemia, Varicose Veins)			
Immunologic (Tuberculosis, AIDS, HIV, Herpes)			
Integumentary (Skin, Acne, Warts, Skin Cancer)			
Musculoskeletal (Arthritis, Osteoporosis, Lupus)			
Neurological (Bell's Palsy, Seizures, Brain Tumor, Vertigo)			
Psychiatric (Anxiety, Bi-Polar, Depression)			
Respiratory (Asthma, Emphysema, Bronchitis, Pneumonia)			

Please list current medications and the condition for which it is being taken:

Current Medication(s):	Condition:	Medication Allergies:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please Fill Out Back of Page

Have you *ever* been diagnosed with the following conditions? If "YES" provide information:

Ocular History	YES	NO	*Explanation, Date Diagnosed, & Treatment.*
Age Related Macular Degeneration (ARMD)			
Glaucoma			
Cataracts			
Eye Injury			
Retinal Disease/Retinal Detachment			
Corneal Disease			
Medical History	YES	NO	*Explanation, Date Diagnosed, & Treatment.*
Diabetes			
High Blood Pressure			
Cancer			
Stroke			
Arthritis			
Ocular Surgeries	YES	NO	*Date*
Lasik/ P.R.K./ P.T.K./ R.K.			
Cataract / YAG / Retina			

Family History	YES	NO	*Relationship to Patient*
Blindness			
Macular Degeneration			
Glaucoma			
Cataracts			
Diabetes			
Cancer			
High Blood Pressure			
Heart Disease			
Other			

Eye Assessment

Date of last eye exam (if not at our office) _____ Name of Doctor/Office_____

I currently wear:

☐ Eyeglasses ☐ Computer Glasses ☐ Bifocal Lenses ☐ Trifocal Lenses

☐ Reading glasses ☐ Prescription Sunglasses ☐ Progressive Lenses ("No-line bifocal")

Are you currently wearing contact lenses? ☐Yes ☐ No if yes, what brand? _____

Have you ever worn contact lenses? ☐Yes ☐ No if yes, what brand? _____

If not currently wearing contacts, are you interested in contact lenses today? ☐Yes* ☐ No *Additional fees apply

Have you had laser vision surgery? ☐Yes ☐ No

Would you like to learn more about laser vision procedures? ☐Yes ☐ No

Are you sensitive to sunlight or glare? ☐Yes ☐ No

Does nighttime driving bother you? ☐Yes ☐ No

Do you work at a computer 3 + hours a day? ☐Yes ☐ No

Do you feel eye fatigue from close-up work? ☐Yes ☐ No

Do you work indoors, outdoors, or both? (Please circle one)

SOCIAL HISTORY

Do you smoke? ☐Yes ☐ No
If yes: How many packs per day? ____

Are you pregnant? ☐Yes ☐ No

Activities/Hobbies: _____

Name _____ **Date** ___/___/___
Print Signature

Reviewed Date	**Patient Initials**	**Reviewed Date**	**Patient Initials**
_____/_____/_____	_____	_____/_____/_____	_____
_____/_____/_____	_____	_____/_____/_____	_____