

Medical History Questionnaire

Full Name: _____ M / F Birth Date: ___ / ___ / ___
 Title: Mr. Mrs. Miss Ms. Dr. Other Marital Status: Single Married Widowed Divorced Separated
 Address: _____ Social Security #: _____
 _____ Home Phone: _____
 Email: _____ Cell Phone: _____ Texting **Y** or **N**
 Communication Preference: Email Postal Phone

Responsible Party if different: _____ **Billing Address if different:** _____

Phone: _____ **Relationship to patient:** _____

Medical Insurance: _____ Vision Insurance: _____

Place of Employment: _____ Work Phone: _____

If Married, Name of Spouse: _____ Spouse's place of work: _____

Name of Medical Doctor: _____ Phone: _____ Last Medical Exam: ___ / ___ / ___

Name of Previous Eye Doctor: _____ Last Eye Exam: ___ / ___ / ___

Whom may we thank for referring you to our office: _____

*** PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED***

We accept Visa, MasterCard, Discover, American Express, and Debit Cards

Ocular / Medical History

Do you wear glasses? No Yes How old are your eyeglasses? _____ Are you getting glasses today? No Yes
 Do you wear contact lenses? No Yes If yes, what type? RGP / Soft Do you sleep in them? No Yes
 How frequently do you replace them? _____ Solution Brand? _____ Are they comfortable? No Yes
 Are you interested in contact lenses today? No Yes Do you wear Safety Glasses for home/work? No Yes
 Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

- | | | |
|---|--|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Redness | <input type="checkbox"/> Halos / Glare |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Eye Pain or Soreness | <input type="checkbox"/> Light Sensitivity |
| <input type="checkbox"/> Flashes | <input type="checkbox"/> Dryness | |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Excess Tearing / Watering | |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Foreign Body Sensation | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Itching | |

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Drooping eyelid |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other: _____ |

List any **medications** you are currently taking (include oral contraceptives, aspirin, over the counter, and home remedies):

Are you **allergic** to any medications? No Yes If yes, please explain: _____

List all major **surgeries** and / or **hospitalizations** you have had: _____

Family History Please note any family history (parents, grandparents, siblings, children):

Blindness	_____	Cancer	_____
Cataract	_____	Diabetes	_____
Crossed Eyes	_____	Heart Disease	_____
Glaucoma	_____	High Blood Pressure	_____
Macular Degeneration	_____	Kidney Disease	_____
Retinal Detachment	_____	Lupus	_____
Arthritis	_____	Thyroid Disease	_____

Preferred Language: English Spanish

- Race:** Native Amer/Alaskan
 Asian
 African Amer.
 Hispanic
 Native Hawaiian/Other Pacific Island
 White

- Ethnicity:** Hispanic/Latino
 Native Hawaiian/Pacific Isl.
 Non Hispanic/Latino

Review of Systems Please check the box beside any problem you currently have in the following areas:

Allergic / Immunologic All Normal
 Allergy / Hayfever

Cardiovascular / Cardiac All Normal
 Arteriosclerosis
 Heart Disease
 High Blood Pressure
 High Cholesterol

Constitutional All Normal
 Fever
 Weight Loss / Gain

Ears, Nose, Mouth, Throat All Normal
 Sinus Congestion
 Dry Throat / Mouth

Endocrine All Normal
 Diabetes - Blood Sugar _____ A1C ____
 Thyroid Disease
 Chronic Fatigue

Gastrointestinal All Normal
 Diarrhea
 Constipation
 Ulcers
 Reflux

Genitourinary All Normal
 Kidney Disease
 Ovarian / Uterine Cancer
 Prostate Cancer

Hematologic / Lymphatic All Normal
 Anemia
 Bleeding Problems
 Breast Cancer

Integumentary (Skin) All Normal
 Cancer
 Rashes
 Easy Bruising

Musculoskeletal All Normal
 Rheumatoid Arthritis
 Muscle Pain
 Joint Pain

Neurological All Normal
 Headaches
 Dizziness
 Seizures
 Stroke

Psychiatric All Normal
 Anxiety
 Depression
 Memory Loss
 Hallucinations

Respiratory All Normal
 Asthma
 Bronchitis
 Emphysema
 Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: _____

Are you pregnant and / or nursing? Yes No

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer. Please check the following box if you wish to discuss your Social History directly with your doctor:*

Do you drive? Yes No If yes, describe any visual difficulty while driving: _____

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

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: _____

Indicate by checking the box if you have been infected with or exposed to: Gonorrhea Hepatitis HIV Syphilis MRSA

Signature: _____ **Date:** _____

For Doctor Use Only:

Signature: _____ Date: _____