Medical History Questionnaire

Dear Patient: All major health insurers and Medicare now require us to obtain in depth patient medical history information. We apologize for the time required to fill out this form and thank you for your cooperation.

Today's Date: _______ / _______ / ___________

Name: ____ Birth Date: _____ / _____ / _______

Reason for visit: ____

Primary Care Physician: ____ Date of last physical: ___________________

Are you allergic to any medications or latex? ❑Yes ❑No If so, which: ____________________________________

Please list the names and dosages of any prescription or over-the-counter medications you are currently taking:

____

____

List all major illnesses (glaucoma, diabetes, high cholesterol, etc.) or injuries (concussion, etc): _____________________

____

List any surgeries you have had (cataract, appendectomy, etc.): ____

Ocular History

Have you ever worn glasses? ❑Yes ❑No When was your last eye exam? __________________________________

Do you currently wear contact lenses? ❑Yes ❑No If yes, what brand and powers? ___________________________

____

Have you ever had LASIK or refractive surgery? ❑Yes ❑No If yes, date of surgery: ____________________________

Are you interested in getting LASIK? ❑Yes ❑No

Have you ever had eye surgery? ❑Yes ❑No If yes, please describe: ____

Check any of the following that you have had: ❑Crossed Eyes ❑Lazy Eye ❑Drooping Eyelid ❑Double Vision ❑Prominent Eyes ❑Glaucoma ❑Retinal Disease ❑Cataracts ❑Eye Injury ❑Eye Infection ❑Dry Eyes ❑Itchy Eyes ❑Floating Spots in Vision ❑Sensitivity to Light / Glare

Hours a day you work on a computer? __________ Would you like to hear about computer glasses? ❑Yes ❑No

Social History

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

Do you smoke? ❑Yes ❑No If YES, how much? ____________ How many years? __________________________

Do you drink alcohol? ❑Yes ❑No If YES, how much? ____________

FLIP PAGE TO COMPLETE BACK SIDE

Review of Systems

Do you *currently have* any problems in the following areas? If YES, please provide details.

	YES	NO	Details (condition, date of diagnosis, and treatment)
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, asthma, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / **LYMPH** (bleeding, high cholesterol, anemia, sickle cell, blood transfusions, etc.)			
ALLERGIC / **IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, etc.)			
CANCER (please list type)			
OTHER			

Family History

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

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Glaucoma	❑	❑	______________________
Macular Degeneration	❑	❑	______________________
Cataract	❑	❑	______________________
Retinal Detachment/Disease	❑	❑	______________________
Diabetes	❑	❑	______________________
High Blood Pressure	❑	❑	______________________
Crossed Eyes	❑	❑	______________________
Blindness	❑	❑	______________________
Cancer	❑	❑	______________________
Heart Disease	❑	❑	______________________
Lupus	❑	❑	______________________
Thyroid Disease	❑	❑	______________________

Other: ____

Doctor's Signature: ______________________________ Date: ______________