Please fill out in INK

Medical History Questionnaire

NAME:____DATE:______________________________

BIRTHDATE:___________SOCIAL SECURITY #_____________LAST EYE EXAM:____________________

NAME OF MEDICAL DOCTOR:___________________________LAST MEDICAL EXAM:_________________

MEDICAL HISTORY

Do you have any allergies to medications? __no __yes If yes, please list:____
____
____

List all major injuries, surgeries, or hospitalizations you have had:____
____

List any previous eye problems you have had, including: crossed eyes, lazy eye, drooping eyelid, bulging eyes, glaucoma, retinal disease, cataracts, eye infections, eye injuries:____
____

WOMEN- Are you pregnant and/or nursing? __no __yes

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	NOT SURE	RELATIONSHIP TO YOU
BLINDNESS	N	Y	?	________________________________
CATARACT	N	Y	?	________________________________
CROSSED EYES	N	Y	?	________________________________
GLAUCOMA	N	Y	?	________________________________
MACULAR DEGENERATION	N	Y	?	________________________________
RETINAL DETACHMENT/DISEASE	N	Y	?	________________________________
ARTHRITIS	N	Y	?	________________________________
CANCER	N	Y	?	________________________________
DIABETES	N	Y	?	________________________________
HEART DISEASE	N	Y	?	________________________________
HIGH BLOOD PRESSURE	N	Y	?	________________________________
KIDNEY DISEASE	N	Y	?	________________________________
LUPUS	N	Y	?	________________________________
THYROID DISEASE	N	Y	?	________________________________
OTHER_____________________	N	Y	?	________________________________

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

__I would prefer to discuss social history information only with the doctor. (please check)

Do you drive? __yes __no If yes, do you have visual difficulty when driving? __yes __no
If yes, please describe:____

Do you use tobacco products? __no __yes If yes, type/amount/how long:_______________________

Do you drink alcohol? __no __yes If yes, type/amount/how long:_____________________________

Do you use illegal drugs? __no __yes If yes, type/amount/how long:_________________________

Have you ever been exposed to or infected with: __gonorrhea __hepatitis __HIV __syphilis

Please turn this form over and complete side 2

Please fill out in INK

Doctor's signature________________________________Date_________________

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas: (If yes, please explain and list medications)

SYSTEM	NO	YES	NOT SURE	EXPLAIN/LIST MEDICATIONS
CONSTITUTIONAL (weight loss/gain)	N	Y	?	________________________________
INTEGUMENTARY (skin)	N	Y	?	________________________________
NEUROLOGICAL				
HEADACHES	N	Y	?	________________________________
MIGRAINES	N	Y	?	________________________________
SEIZURES	N	Y	?	________________________________
EYES				
LOSS OF VISION	N	Y	?	________________________________
BLURRED VISION	N	Y	?	________________________________
DISTORTED VISION/HALOES	N	Y	?	________________________________
LOSS OF SIDE VISION	N	Y	?	________________________________
DOUBLE VISION	N	Y	?	________________________________
DRY EYES	N	Y	?	________________________________
MUCOUS DISCHARGE	N	Y	?	________________________________
REDNESS	N	Y	?	________________________________
SANDY/GRITTY FEEL	N	Y	?	________________________________
ITCHING	N	Y	?	________________________________
BURNING	N	Y	?	________________________________
FOREIGN BODY SENSATION	N	Y	?	________________________________
EXCESS TEARING/WATERY	N	Y	?	________________________________
GLARE/LIGHT SENSITIVITY	N	Y	?	________________________________
EYE PAIN OR SORENESS	N	Y	?	________________________________
INFECTION OF EYE OR LID	N	Y	?	________________________________
STYES OR CHALAZION	N	Y	?	________________________________
FLASHES/FLOATERS IN VISION	N	Y	?	________________________________
TIRED EYES	N	Y	?	________________________________
EARS, NOSE, MOUTH, THROAT				
ALLERGIES/HAYFEVER	N	Y	?	________________________________
SINUS CONGESTION	N	Y	?	________________________________
RUNNY NOSE	N	Y	?	________________________________
POST-NASAL DRIP	N	Y	?	________________________________
CHRONIC COUGH	N	Y	?	________________________________
DRY THROAT/MOUTH	N	Y	?	________________________________
RESPIRATORY				
ASTHMA	N	Y	?	________________________________
CHRONIC BRONCHITIS	N	Y	?	________________________________
EMPHYSEMA	N	Y	?	________________________________
VASCULAR/CARDIOVASCULAR				
HEART PAIN	N	Y	?	________________________________
HIGH BLOOD PRESSURE	N	Y	?	________________________________
HEART/VASCULAR DISEASE	N	Y	?	________________________________
GASTROINTESTINAL				
DIARRHEA	N	Y	?	________________________________
CONSTIPATION	N	Y	?	________________________________
GENITOURINARY(genitals/kidney/bladder)	N	Y	?	________________________________
BONES/JOINTS/MUSCLES				
RHEUMATOID ARTHRITIS	N	Y	?	________________________________
MUSCLE PAIN	N	Y	?	________________________________
JOINT PAIN	N	Y	?	________________________________
LYMPHATIC/HEMATOLOGIC				
ANEMIA	N	Y	?	________________________________
BLEEDING PROBLEMS	N	Y	?	________________________________
ENDOCRINE (thyroid/other glands)	N	Y	?	________________________________
DIABETES	N	Y	?	________________________________
ALLERGIC/IMMUNOLOGIC	N	Y	?	________________________________
PSYCHIATRIC	N	Y	?	________________________________

Please list any medications that you take that are not listed above:

____

____

____

____

Thank you for taking the time to fill out our questionnaires.