

Eye Care Group:

Medical History Questionnaire

NAME: _____ **Gender:** M / F **Today's Date:** ____ / ____ / ____
Address: _____ **Home Phone:** _____
City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____
Birth Date: ____ / ____ / ____ **Social Security #:** ____ / ____ / ____ **Last Eye Exam:** ____ / ____ / ____
Parent/Guardian: _____ **Last Medical Exam:** ____ / ____ / ____
Name of Medical Doctor: _____ **Insurance:** _____
Who can we thank for your referral? _____

Medical History:

List all medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):

None _____

Do you have any allergies to medications? No Yes If yes, please specify: _____

List **major** injuries, surgeries and/or hospitalizations you have had: (including eye surgeries like cataracts, LASIK, etc.)

None _____

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old are they? _____

Do you wear contact lenses? No Yes If yes, how old are they? _____

If you wear contacts: Soft Rigid Are they comfortable? No Yes

Brand: _____ Care Solution: _____ Wearing Schedule: _____

Personal Ocular (Eye) History: Please note any of the following that may be or has affected you.			Family Health History: Please note any family history (parents, grandparents, siblings, children; living or deceased):			
DISEASE / CONDITION	NO	YES	DISEASE / CONDITION	NO	YES	RELATION
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (Eye Turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus (Eye Turn)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual Field Loss	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two

Social History: *This information is kept strictly confidential. (You may discuss this portion directly with the doctor if you prefer.)*

Yes, I would like to discuss my Social History information directly with my doctor. (check box)

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

If driving difficulty, please specify: _____

Occupation/Hobbies & Special Visual Needs: _____

Do you have a need for Safety Glasses? No Yes

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: None HIV Syphilis Chlamydia Hepatitis

Review of Systems: Do you currently have any significant problems in the following areas?

SYSTEM	NO	YES	SYSTEM	NO	YES
ALLERGY			HEAD/DENTAL		
Medications (See Front)	<input type="checkbox"/>	<input type="checkbox"/>	Ears	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR			HEMATOLOGIC/LYMPHATIC (Blood)		
Angina/Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bypass/Stent (Date _____)	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack (Date _____)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNOLOGIC		
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
CONSTITUTIONAL			Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>
Disorientation	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Marked Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (Skin)		
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE (Glandular)			Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Pituitary	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC		
GASTROINTESTINAL			Headache	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Weakness in Limb	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC (Mental Health)		
GENTOURINARY			Specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Bladder _____	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
Kidney _____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever been diagnosed with cancer of any kind? No Yes Type: _____

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

Office Use Only
_____, O.D.
Doctor's Signature
Date