

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Today's Date _____/_____/_____

Name of Optometrist _____ Last Eye Exam _____/_____/_____

Name of Medical Doctor _____ Last Medical Exam _____/_____/_____

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

DIAGNOSED EYE PROBLEMS: None

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergic | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Amblyopia
(Lazy Eye) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other Retinal Problems
<i>Specify</i> _____ |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Herpes | <input type="checkbox"/> Strabismus (Crossed or "Wall" Eyes) |
| <input type="checkbox"/> Corneal Problems
<i>Specify</i> _____ | <input type="checkbox"/> Iritis | <input type="checkbox"/> Trichiasis |
| | <input type="checkbox"/> Lid Problems
<i>Specify</i> _____ | |

EYE MEDICATION AND DOSAGE

- None
- _____
- _____
- _____
- _____

PREVIOUS EYE SURGERIES & DATE

- None
- _____
- _____
- _____
- _____
- _____

PREVIOUS EYE INJURIES & DATE

- None
- _____
- _____
- _____
- _____
- _____

- | | | |
|--------------------------|-------------------------------|--------------------------------|
| Yes | No | How Long |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Contact Lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of lenses: | <input type="checkbox"/> Soft | <input type="checkbox"/> Rigid |

Other Eye Or Glasses Problems:

- _____
- _____
- _____
- _____

Chart # _____

*** Please turn this form over and complete side two ***

DIAGNOSED MEDICAL PROBLEMS

- Allergies
- Asthma
- Arthritis
- Bleeding Tendency
- Cancer
- Diabetes
- Emphysema
- Hay Fever
- Headaches
- Heart Trouble
- High Blood Pressure
- Now Pregnant
- Sinus Infections
- Skin Disorders
- Thyroid Trouble

ALLERGIES TO MEDICATIONS:

SYSTEMIC MEDICATION

PREVIOUS SURGERIES OR HOSPITALIZATIONS

SOCIAL HISTORY

___ This information is kept strictly confidential.
 However, you may discuss it directly with your doctor if you prefer. Yes, I prefer to discuss my social history directly with my doctor.

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

Do you drink alcohol? No Yes

If yes, amount _____

Do you use tobacco products? No Yes

If yes, amount _____

Do you use illegal drugs? No Yes

Occupation _____

Have you been exposed/infected with:

- Hepatitis
- HIV
- STD

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
CONSTITUTIONAL				RESPIRATORY			
Change in Sleep Pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR			
INTEGUMENTARY (Skin)				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rashes/Blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				GASTROINTESTINAL			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				GENITOURINARY			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES			
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				LYMPHATIC/HEMATOLOGIC			
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruising/Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC			
Excessive Hunger/Thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, MOUTH, THROAT				Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

Chart # _____