



Medical History Questionnaire

Full Name: _____ Birth Date: _____/_____/_____
 Address: _____ Social Security #: _____
 _____ Home Phone: _____
 Email Address: _____ Cell Phone: _____
 _____ Work Phone: _____
 Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Care Physician: _____ Last Medical Exam: _____/_____/_____
 Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Responsible Party (if different): _____ Relation to Patient: _____
 Billing Address (if different): _____ Driver's License #: _____

Vision Insurance: VSP Eye Med Other: _____ Policy #: _____
 Primary Medical Insurance: _____ Policy #: _____
 Secondary Medical Insurance: _____ Policy #: _____

OCULAR HISTORY: Do you wear glasses? No Yes If yes, how old are your present lenses? _____
 Do you wear contact lenses? No Yes if yes, what type? Rigid Soft Toric Multifocal/Monovision
 Brand: _____ How often do you replace them: _____ Do you wear them: Full time Part time

Are you currently experiencing any of the following problems with your eyes? Check box if YES
 Blurred Vision Loss of Vision Loss of side vision Distorted Vision Double vision
 Tired Eyes Flashes Floaters Halos/Glare Light Sensitivity Dryness
 Burning Itching Redness Excess tearing Pain/Soreness Mucous Discharge
 Inflammation of Eye lid Styes/Chalazion Other _____

Have you been diagnosed with any of the follow ocular problems? Check box if YES
 Cataracts Glaucoma Retinal Detachment Macular Degeneration Retinal disease
 Strabismus/Crossed Eye Amblyopia/Lazy Eye Dry Eye Uveitis/Iritis Eye Injury
 Other _____

Have you had any eye related surgeries? Refractive (LASIK, PRK, RLE, RK, Etc.), Medical Eye Surgery:

MEDICAL HISTORY:

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter, etc.)

Allergies to any medications: No Yes If yes, please note: _____

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

Are you pregnant or nursing? No Yes **History of illegal drug use:** No Yes _____

Do you or have you used Tobacco Products: No Yes, Type: _____ Frequency: _____ Amount: _____

Do you drink alcohol: No Yes < 7 drinks a week 7-14 drinks a week > 14 drinks a week

Have you ever been exposed or infected with HIV Syphilis Hepatitis Gonorrhea

FAMILY HISTORY: please note who: parents, grandparents, siblings, children; living or deceased ADOPTED

- Cataract _____
- Macular Disease _____
- Glaucoma _____
- Retinal Detachment _____
- Retinal Disease _____
- Blindness _____
- Strabismus _____
- Heart Disease _____

- Hypertension _____
- Diabetes _____
- Arthritis _____
- Uveitis _____
- Ankylosing Spondylitis _____
- Kidney Disease: _____
- Other: _____

REVIEW OF SYSTEMS: Check the box beside any problem you are **CURRENTLY** experiencing and/or being treated for:

- ALLERGIC / IMMUNOLOGIC** All Normal
 - Allergy / Hay Fever
- 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
 - Thyroid Disease
 - Chronic Fatigue
- GASTROINTESTINAL** All Normal
 - Diarrhea / Constipation
 - IBS / Crohn's Disease
 - 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
 - Migraines
 - 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: _____

Patient Signature: _____ Date ____/____/____ Doctor Signature: _____