Patient & Medical History Questionnaire

Today's Date _____/_____/____

(Please circle)
(Mr. / Mrs. / Ms. / Miss / Dr. **)** Name _____Birthdate_____/_____/_____

Employer_____Bus.Number_____Occupation_____

Name of Spouse/Guardian_____ Emergency Contact Name_____Phone_____

Referred By_____ Hobbies_____

Name of Med Doctor _____Last Medical Exam _____/_____/_____Last Eye Exam _____/_____/_____

Dr.'s Address _____Dr.'s Ph # _____

Medical History

Do you have any allergies to medications/**non**-medication? □ No □ Yes If yes, please list: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): □ **NONE**

List all major surgeries and/or hospitalizations you have had **and when (last 5 years) .** □ **NONE** _____

Mark any of the following that you have had: □ **NONE** □ Laser Eye Surgery (when?_____) □ Cataracts □ Crossed Eyes
□ Lazy Eye □ Drooping Eyelid □ Glaucoma □ Retinal Disease □ Eye Infections □ Eye Injury □ Other _____

Are you pregnant and/or nursing? □ No □ Yes If pregnant, how many months: _____

Do you wear glasses? □ No □ Yes If yes, how old are your current pair of lenses? _____

Do you wear contact lenses? □ No □ Yes Brand: _____ Are they comfortable? □ Yes □ No

Type: □ Rigid □ Soft □ Extended Wear □ Disposable Wearing Schedule:_____ Solutions: _____

Are you interested in Contacts? □Yes □ No **Are you interested in Lasik?** □Yes □ No

Family History

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

Disease / Condition	Please Circle		Relationship to You (please specify Maternal or Paternal)
Blindness (Disease / Injury)	**No**	**Yes**	
Cataract	**No**	**Yes**	
Crossed Eyes / Lazy Eye	**No**	**Yes**	
Glaucoma	**No**	**Yes**	
Macular Degeneration	**No**	**Yes**	
Retinal Detachment	**No**	**Yes**	
Diabetes	**No**	**Yes**	
Heart Disease	**No**	**Yes**	
High Cholesterol	**No**	**Yes**	
High Blood Pressure	**No**	**Yes**	
Other _____	**No**	**Yes**	

Social History

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes If yes, please describe:

Do you use tobacco products? □ No □ Former User □ Yes If yes, amount / how long: _____

Do you drink alcohol? □ No □ Yes If yes, 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 □ No □ Yes Syphilis □ No □ Yes HIV □ No □ Yes Hepatitis □ No □ Yes

Please turn this form over and complete side two

Review of Systems

Are you currently or have in the last month experienced any of the following: (if YES, please explain)

SYSTEM	Please Circle		Explain
NEUROLOGIC			
Headaches/Migraines	**No**	**Yes**	_____
Migraines	**No**	**Yes**	_____
Seizures	**No**	**Yes**	_____
EYES			
Loss of Vision	**No**	**Yes**	_____
Blurred Vision	**No**	**Yes**	_____
Loss of Side Vision	**No**	**Yes**	_____
Double Vision	**No**	**Yes**	_____
Dryness or Sandy Feeling	**No**	**Yes**	_____
Mucous Discharge	**No**	**Yes**	_____
Redness	**No**	**Yes**	_____
Itching	**No**	**Yes**	_____
Burning	**No**	**Yes**	_____
Foreign Body Sensation	**No**	**Yes**	_____
Excess Tearing / Watering	**No**	**Yes**	_____
Glare/Halos	**No**	**Yes**	_____
Light Sensitivity	**No**	**Yes**	_____
Eye Pain or Soreness	**No**	**Yes**	_____
Chronic Infection of Eye or Lid	**No**	**Yes**	_____
Styes or Chalazion	**No**	**Yes**	_____
Flashes of Light	**No**	**Yes**	_____
Floaters in Vision	**No**	**Yes**	_____
Eye Fatigue	**No**	**Yes**	_____

Have you been diagnosed or are being monitored for the following conditions?

INTEGUMENTARY			
Skin Conditions	**No**	**Yes**	_____
EARS, NOSE, MOUTH			
Allergies Hayfever	**No**	**Yes**	_____
Chronic Cough	**No**	**Yes**	_____
Dry Mouth	**No**	**Yes**	_____
RESPIRATORY			
Asthma	**No**	**Yes**	_____
Emphysema	**No**	**Yes**	_____
ENDOCRINE			
Thyroid, Other Glands	**No**	**Yes**	_____
VASCULAR			
Diabetes	**No**	**Yes**	_____
High Cholesterol	**No**	**Yes**	_____
High Blood Pressure	**No**	**Yes**	_____
Heart Disease	**No**	**Yes**	_____
LYMPHATIC / HEMATOLOGIC			
Anemia	**No**	**Yes**	_____
Bleeding Problems	**No**	**Yes**	_____
GASTROINTESTINAL			
Irritable Bowel Syndrome	**No**	**Yes**	_____
GENITOURINARY			
Kidney, Bladder	**No**	**Yes**	_____
BONES / JOINTS / MUSCLES			
Arthritis	**No**	**Yes**	_____
Osteoarthritis	**No**	**Yes**	_____
Rheumatoid Arthritis	**No**	**Yes**	_____
Muscle Pain / Joint Pain	**No**	**Yes**	_____
Osteoporosis	**No**	**Yes**	_____
PSYCHIATRIC (anxiety / depression)	**No**	**Yes**	_____