**Medical History Questionnaire**

PLEASE PRINT AND COMPLETE ALL INFORMATION

Name: _____ Date: _____ Date of Birth: ___ / ___ / ___

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Name of Spouse (or Parents of Child) _____

Age: _____ Home Phone (_____) _____ Email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

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

Medical Insurance: _____ ID Number: _____

Group Number; _____ SS# of Policy Holder: _____ DOB of Policy Holder: ___ / ___ / ___

Referred by: _____ ☐ Phone Book ☐ Internet ☐ Other _____

**Medical History:**

What Medications are you taking? _____

_____

Do you have any allergies to any medications? ☐ NO ☐ YES **IF YES,** List the medications: _____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.): _____

_____

Are you pregnant and/or nursing? ☐ NO ☐ YES
When was your last eye exam? _____
Do you wear glasses? ☐ NO ☐ YES If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ☐ NO ☐ YES If yes, how old is your present pair of lenses? _____
Type of contact lenses? _____ Are they comfortable? ☐ NO ☐ YES

**Do you have any problems in the following areas? If yes, please explain.**

| | YES | NO | EXPLANATION OF PROBLEM |
|---|---|---|---|
| **EYES (Glaucoma, Cataract, etc.)** | | | |
| Loss of Vision | | | |
| Blurred Vision | | | |
| Floaters | | | |
| Fluctuating Vision | | | |
| Distorted Vision (halos) | | | |
| Loss of Side Vision | | | |
| Double Vision | | | |
| Dryness | | | |
| Mucous Discharge | | | |
| Redness | | | |
| Sandy or Gritty Feeling | | | |
| Itching / Burning | | | |
| Foreign Body Sensation | | | |
| Excess Tearing / Watering | | | |

| | | | |
|---|---|---|---|
| Glare/Light Sensitivity | | | |
| Eye Pain or Soreness | | | |
| Infection of Eye or Lid (Blepharitis, Stye) | | | |
| Tired Eyes | | | |
| Crossed Eyes, Lazy Eye | | | |
| Drooping Eyelid | | | |

| | YES | NO | EXPLANATION OF PROBLEM |
|---|---|---|---|
| **GENERAL/ CONSTITUTIONAL** | | | |
| Fever | | | |
| Weight Loss | | | |
| Other | | | |
| **EARS, NOSE, THROAT** (Sinus, Ear Infection, Chronic Cough, etc.) | | | |
| **CARDIOVASCULAR** (Heart, Vessels, etc.) | | | |
| **RESPIRATORY** (Asthma, Emphysema, etc.) | | | |
| **GASTROINTESTINAL** (Stomach, Ulcers, Intestinal Disease, etc.) | | | |
| **GENITAL, KIDNEY, BLADDER** | | | |
| **MUSCLE, BONES, JOINTS** (Arthritis, etc.) | | | |
| **SKIN** (Acne, Warts, Skin Cancer, etc.) | | | |
| **NEUROLOGICAL** ( Multiple Sclerosis, etc.) | | | |
| **PSYCHIATRIC** (Anxiety, Depression, etc.) | | | |
| **ENDOCRINE** (Diabetes, Hypothyroid, etc.) | | | |
| **BLOOD/LYMPH** ( Anemia, etc.) | | | |
| **ALLERGIC/ IMMUNOLOGIC** (Hay Fever, Lupus, Sjogrens, etc.) | | | |

**FAMILY HISTORY** **M=MOTHER, F=FATHER, S= SIBLING, GP=GRANDPARENT**

| DISEASE | YES | NO | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| Blindness | | | |
| Glaucoma | | | |
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart Disease or High Blood Pressure | | | |
| Stroke | | | |
| Other | | | |

## SOCIAL HISTORY

Do you drive? ☐ YES ☐ NO
Do you have visual difficulty when driving? ☐ YES ☐ NO
Do you have problems with night vision? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO _____
Do you use tobacco products? ☐ YES ☐ NO _____
Have you ever had a blood transfusion? ☐ YES ☐ NO
History reviewed. ☐ No changes ☐ Additions as noted above.

**OPTOMETRIST'S SIGNATURE:** _____ **DATE:** _____