# Medical History Questionnaire

(Please Print)

Name: ____________________________________ Date: _____/_____/________ Date of Birth: _____/______/__________
Last medical exam: _____/_____/________ Medical Doctor (name,location):________________________________________
Last eye exam: ______/_____/________ Last Eye Care Provider:__________________________________________________
Pharmacy (name, location, phone):__________________________________________________________________________

## Past Eye History

Have you ever had any eye injuries? ☐ No ☐ Yes: (list)________________________________________________________
Have you ever had any eye surgeries? ☐ No ☐ Yes (list)_______________________________________________________
List any eye drops you use :_______________________________________________________________________________
Do you wear glasses? ☐No ☐Yes / How old is you present pair of lenses?__________________________________________
Do you wear contact lenses? ☐No ☐Yes / How old is your present pair of lenses?__________________________________
Type of contact lenses: ☐Rigid ☐Soft Wearing Schedule: ☐Remove daily ☐Sleep in lenses
How often do you throw away your lenses? ______________________ Are your lenses comfortable? _________________

Do you have or ever had any of the following eye conditions or diseases? Please check all that apply.
☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment/ Disease ☐Dry Eyes ☐ Eye Infections
☐Loss of Vision/Side Vision ☐ Itchy Eyes ☐Double Vision ☐Blurred Vision ☐Flashes/Floaters ☐ Crossed Eyes
☐Lazy Eyes ☐Drooping Eyelid ☐Other ______________________________________________________________________

## Past Medical History

List all medications:_______________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
Allergies: ☐None ☐ Yes(list)_________________________________________________________________________________
List all major injuries, surgeries and / or hospitalizations you have had: ______________________________________
___________________________________________________________________________________________________________
Are you pregnant ? ☐No ☐Yes / Weeks __________ Are you Nursing? ☐No ☐Yes
Do you have any medical conditions? Please check all that apply. ☐Diabetes ☐ High Blood Pressure ☐Heart Disease ☐High Cholesterol ☐Thyroid Disorder ☐Autoimmune Disease (name:________________) Please list any additional medical conditions.___________________________________________________________________________________
___________________________________________________________________________________________________________

**Family History: (Check all that apply to your blood relatives)**

☐Blindness ☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Lazy Eye ☐ Retinal Disease/Detachment ☐Diabetes
☐Heart Disease ☐Stroke ☐ High Blood Pressure ☐Arthritis ☐Kidney Disease ☐Thyroid Disorder ☐Autoimmune
☐Other ___________________

## Social History

Smoking Status: ☐ Current every day smoker ☐Current some day smoker ☐Former Smoker ☐Never smoked
☐Smoker, current status unknown ☐ Unknown if ever smoked
If smoker: How much?_____________ How long? _____________ When quit? ______________
Alcohol Use: ☐None ☐ Occasional drinker ☐Everyday drinker Type______________ How long?______________
Drugs: ☐No ☐Yes: type/amount/how long: ___________________________________________________________
Check if you have ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐Hepatitis

**OVER**

## Review of Systems

Do you currently, or have you ever had any problems in the following areas:

***Constitution***

Fatique/ Weakness ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight gain/loss ☐ Yes ☐ No
Jaw pain when chewing ☐ Yes ☐ No
Scalp Tenderness ☐ Yes ☐ No

***Skin***

Rashes/Sores ☐ Yes ☐ No
Rosacea ☐ Yes ☐ No
Hives/Eczema ☐ Yes ☐ No

***Neurological***

Headaches/Migraines ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Tremors ☐ Yes ☐ No

***Eyes***

Other not previous listed ☐ Yes ☐ No

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***Ear, Nose and Throat***

Hard of Hearing ☐ Yes ☐ No
Ringing in Ears ☐ Yes ☐ No
Dizziness/Vertigo ☐ Yes ☐ No
Sinus Congestion/Pressure ☐ Yes ☐ No

***Respiratory***

Asthma ☐ Yes ☐ No
Chronic Bronchitis ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Congestion ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No

***Cardiovascular***

Heart attack ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Irregular heart beat ☐ Yes ☐ No
Vascular disease ☐ Yes ☐ No

***Gastrointestinal***

Esophageal Reflux ☐ Yes ☐ No
Digestive Disorder ☐ Yes ☐ No
Ulcer ☐ Yes ☐ No
Cirrhosis ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No

***Genitourinary***

Kidney Stones ☐ Yes ☐ No
Urinary Disorder ☐ Yes ☐ No
History of STD's ☐ Yes ☐ No

***MusculoSkeletal***

Rheumatoid Arthritis ☐ Yes ☐ No
Osteoarthritis ☐ Yes ☐ No
Myasthenia Gravis ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No

***Lymphatic/Hematologic***

Anemia ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Easy Bruising ☐ Yes ☐ No
Aspirin Use ☐ Yes ☐ No

***Endocrine***

Thyroid (low) ☐ Yes ☐ No
Thyroid (high) ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Pituitary Disorder ☐ Yes ☐ No

***Psychiatric***

Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Bipolar ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No
Difficulty Sleeping ☐ Yes ☐ No

***Immunologic***

Allergies ☐ Yes ☐ No
Hay Fever ☐ Yes ☐ No
Lupus ☐ Yes ☐ No
Sarcoidosis ☐ Yes ☐ No
Sjogrens ☐ Yes ☐ No

***Other***

Cancer ☐ Yes ☐ No

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____________________

Explanations:

______________________________________________ ________________________

Patient/Guardian Signature Date

______________________________________________ ________________________

Doctor Signature Date Reviewed