MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Today's Date_____/_____/_____
Address:_____ Home Phone:_____
_____ Office Phone:_____
How did you hear about our office:_____ Birth Date:_____/_____/_____
Occupation:_____ Last Eye Exam:_____/_____/_____
Do you have vision care insurance? No ☐ Yes ☐
VSP ☐ Medicare ☐ Medi-Cal ☐ Blue Cross ☐ MESC ☐ Other ☐
SS #_____/_____/_____ Insured Members SS#_____/_____/_____ Insured Members Birth Date ____/____/____/

Medical History

Do you have medical insurance? No ☐ Yes ☐ If yes, who is your carrier? _____
Name of primary care physician:_____ Last Medical Exam_____
Are you presently under a physician's care? No ☐ Yes ☐ If yes, for what conditions?_____
_____
List any medications you take(Including oral contraceptives, aspirin, over the counter medications and home remedies or herbs): _____
_____
Do you have any allergies to medications? No ☐ Yes ☐ If yes, explain:_____
_____
List all major injuries, surgeries and/or hospitalizations you have had:_____
_____
Are you pregnant and/or nursing? No ☐ Yes ☐
Do you wear glasses? No ☐ Yes ☐
Do you wear contact lenses? No ☐ Yes ☐
Type of contact lenses: Rigid ☐ Soft ☐ Extended Wear ☐ Other ☐
Are you interested in Laser Vision Correction? No ☐ Yes ☐

Self and Family History

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

DISEASE/CONDITIONS	Family	Self	RELATIONSHIP TO YOU
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Lazy Eye	☐	☐	_____
Drooping eyelid	☐	☐	_____
Prominent eye	☐	☐	_____
Eye Infections or injury	☐	☐	_____
Others_____	☐	☐	_____

Please turn this form over and complete side two

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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 ☐ Yes If Yes, type/amount/how long: _____

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

Do you engage in any occupational or recreational activities which need special visual requirements (e.g. Computer use, golfing, musical instruments, etc.) _____

_____

Review of Systems

Do you have any problems in the following areas:

System	No	Yes
Constitutional	☐	☐
Fever, Weight Loss/Gain	☐	☐
Integumentary (Skin)	☐	☐
Neurological	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes	☐	☐
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Visions/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	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Styes or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endrocrine	☐	☐
Thyroid/Other Glands	☐	☐

	No	Yes
Ear, Nose, Mouth, Throat	☐	☐
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory	☐	☐
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular	☐	☐
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary	☐	☐
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles	☐	☐
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic	☐	☐
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric	☐	☐

If you answered Yes to any of the above or have a condition not listed, please explain and list medication: _____

_____

_____

_____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____