Medical History Questionnaire

Chart # ____________
Dr.'s initials ________

Patient's Name ____
Birthdate ______________ Date of last exam (if not here)____________
Name/location of previous eye doctor/clinic (if not here) _________________________________
Reason for today's visit ____

Medical/Social History

Please list all medications you are currently taking ____
____
Please list all medications you are allergic to ____
____
Please list all major injuries, surgeries, and/or hospitalizations you have had __________________
____
What hobbies or sports do you participate in? ____

Please check any of the following conditions that apply to you

____ Frequent headaches____ Allergies ____ Pregnant/nursing____ Given birth within 6 months

Do you use tobacco products? ____ Yes ____ No ____ Occasionally
Do you use alcoholic beverages? ____ Yes ____ No ____ Occasionally
Do you use any other substances? ____ Yes ____ No ____ Occasionally

Family and Ocular History

Have you ever had any of the following conditions involving your eyes? (Please check)

____ Eye surgery ____ Eye injury ____ Conjunctivitis
____ Medical treatment ____ Severe pain ____ Sensitivity to light
____ Floaters or spots ____ Double vision ____ Eye infection or disease
____ Eye strain ____ Loss of vision ____ Eyes burn, itch, or water
____ Blurred vision ____ Poor near vision ____ Iritis
____ Blindness ____ Retinal problems ____ Lazy eye
____ Others, please name ____

Have you or any of your immediate family members been diagnosed with:

Glaucoma _____Self _____Family
Cataracts _____Self _____Family
Diabetes _____Self _____Family
Heart condition _____Self _____Family
Macular degeneration _____Self _____Family
Lazy eye _____Self _____Family
High blood pressure _____Self _____Family
Other ___________________________________

Do you currently wear glasses? ____ Yes ____ No If yes, when do you wear your glasses?

____ All the time ____ Reading/near work ____ Distance tasks only
____ Computer work ____ Work safety ____ Other ________________

Have you ever worn contact lenses? ____ Yes ____ No
If not, are you interested in wearing contacts? ____ Yes ____ No
Are you interested in refractive/vision correction surgery? ____ Yes ____ No

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child duting the period of such eyecare to third party payers and/or health practitioners.

Signature ____ Date _________________________

Review of Systems (Please circle any conditions you have experienced recently)

For Patient: ____Chart#________________

Constitutional

Fever	Yes	No
Chills	Yes	No
Night sweats	Yes	No
Weight loss	Yes	No
Fatigue	Yes	No
Trauma	Yes	No

ENT

Sore throat	Yes	No
Difficulty swallowing	Yes	No
Sores in mouth/lips	Yes	No
Runny nose	Yes	No
Sinus problems	Yes	No
Earache	Yes	No
Trouble hearing	Yes	No
Ringing/Tinitis	Yes	No

Cardiovascular

Chest pain	Yes	No
Palpitations	Yes	No
Shortness of breath	Yes	No
Vascular disease	Yes	No
Stroke	Yes	No

Respiratory

Cough	Yes	No
Wheezing	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No

Gastrointestinal

Nausea/Vomiting	Yes	No
Crohn's	Yes	No
Ulcer	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Colitis	Yes	No

Genitourinary

Pain/burning with urination	Yes	No
Hesitancy when urinating	Yes	No
Frequent urination	Yes	No
Blood in urine	Yes	No
Incontinence	Yes	No

Hematological/Lymphatic

Easy bruising/bleeding	Yes	No
Excessive clotting	Yes	No
Swollen lymph glands	Yes	No
Blood transfusion	Yes	No

Musculoskeletal

Joint pain	Yes	No
Bone pain	Yes	No
Fibromyalgia	Yes	No
Muscular dystrophy	Yes	No
Osteoarthritis	Yes	No

Skin

Rash	Yes	No
Itching	Yes	No
Sores	Yes	No
Bleeding	Yes	No

Neurological

Headaches	Yes	No
Seizures	Yes	No
Dizziness	Yes	No
Weakness	Yes	No
Numbness	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No
Multiple sclerosis	Yes	No

Psychiatric

Sleep disturbance	Yes	No
Depression	Yes	No
Anxiety	Yes	No

Endocrine

Increased thirst	Yes	No
Non insulin dependent diabetes	Yes	No
Insulin dependent diabetes	Yes	No
Thyroid dysfunction	Yes	No
Hormonal dysfunction	Yes	No

Extremities

Swelling in arms/legs	Yes	No
Arms/legs turning blue	Yes	No
Tingling sensation	Yes	No

Signature of person completing this form ___________________________________

Date ________________________________