

Medical History Questionnaire

Appointment Date _____
Patient's Name (please print) _____ Birth Date _____ M or F _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Employer/Occupation _____
Emergency Contact _____ Phone Number _____
Date of Last Eye Exam _____ Name of Previous Eye Doctor _____
Date of Last Medical Exam _____ Name of Medical Doctor _____ Phone _____

Social History

Are you in good health? Yes No
Do you smoke? Yes No How often? _____
Do you drink alcohol? Yes No How often? _____
Do you take medications? Yes No Please list (Include vitamins, OTC, etc.) _____

Do you have any allergic reactions to medications or other substances? Yes No
If yes, please list. _____

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

Personal History

Do you have any of the following?

Dry Eyes Glaucoma Crossed Eyes Drooping Eyelid Cataracts
 Blurred Vision Retinal Disease Lazy Eye Prominent Eyes Blindness

Any eye problems at this time? Please explain. _____

Please list any eye injuries, infections or surgeries you've had. _____

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Do you wear glasses? Yes No If yes, how old is your present pair of lenses? _____

Do you wear contacts? Yes No If yes, how old is your present pair of lenses? _____

Type of contacts: Rigid Soft Extended Wear Other Are they comfortable? Yes No

Do you have family history of any of the following?

Diabetes Glaucoma High Blood Pressure Blindness
 Macular Degeneration Retinal Detachment Cataracts Other

Please explain any boxes you have checked. _____

Review of Systems

Do you have any problems with any of these systems? If yes, please check box.

Allergic/Immunologic Neurological (Migraines, etc.) Hematologic/Lymphatic (Anemia)
 Eyes Constitutional (Weight gain/loss) Respiratory (Asthma, Emphysema)
 Musculoskeletal (Arthritis, etc.) Genitourinary (Kidney, Bladder) Endocrine (Thyroid, Diabetes)
 Cardiovascular (Heart, Hypertension) Psychiatric (Depression, Anxiety, etc.) Integumentary (Skin)
 Gastrointestinal (Diarrhea, Constipation) Ear, Nose, Mouth & Throat Surgeries

Please explain any box you have checked. _____