Medical History Questionnaire

PLEASE PROVIDE A COPY OF YOUR MEDICAL INSURANCE CARD AS WELL AS ANY INFORMATION YOU HAVE REGARDING YOUR VISION PLAN

Patient's Name: _____ Today's Date: _____ DOB: __/__/__

Sex: **M / F** Age: ____ Patient's Social Security #: ____ - ___ -____ Phone Number: _____

Address: _____ Email: _____

Medical History

List **ANY** medications you take (including contraceptives or over the counter):

_____

_____

_____

_____

Do you have any drug allergies? **Y/ N**

_____

When was your last eye exam? ___/___/___

Hours of computer usage per day: _____

Are you pregnant or nursing? **Y / N**

Reason for today's visit:

- ☐ Annual visit
- ☐ Blurry vision
- ☐ Flashes of light
- ☐ Floaters/spots in vision
- ☐ Headaches/eye pain
- ☐ Itchiness/discharge
- ☐ Fatigue/eye strain
- ☐ Night Vision Difficulty

Do you wear contact lenses? **Y / N**

If yes, check all that apply:

- ☐ Soft
- ☐ Rigid Gas-Permeable (RGP)
- ☐ Astigmatism/Toric
- ☐ Multifocal

Do you wear glasses? **Y / N**

How old are they? _____

Check all that apply:

- ☐ Readers - over the counter
- ☐ Single vision
- ☐ Computer
- ☐ Bifocals/progressive
- ☐ Prescription sunglasses

Have you ever had eye surgery or major eye injury? **Y / N**

Please list:

_____

Family History

☐Unknown/Adopted

Have you ever been diagnosed or treated for any of the following health problems? (Please list relationship for family only)

Disease/Condition		Relationship
Blindness		Y / N / F _____
Cataract		Y / N / F _____
Crossed Eyes/Lazy Eye		Y / N / F _____
Glaucoma		Y / N / F _____
Macular Degeneration		Y / N / F _____
Retinal Problems		Y / N / F _____
Arthritis		Y / N / F _____
Cancer		Y / N / F _____
Heart Disease		Y / N / F _____
High Blood Pressure		Y / N / F _____
Kidney Disease		Y / N / F _____
Lupus		Y / N / F _____
Thyroid Disease		Y / N / F _____
Cholesterol		Y / N / F _____
Stroke/Seizures		Y / N / F _____
Diabetes	TYPE____	Y / N / F _____
TBI		Y / N

Social History

- ☐ Yes, I would prefer to discuss my social history directly with the doctor.

Do you use tobacco products? **Y/ N**

Do you drink alcohol? **Y/ N**

Do you use illegal drugs? **Y/ N**

Have you ever been exposed to or infected with:

- ☐ Gonorrhea
- ☐ Hepatitis
- ☐ HIV
- ☐ Syphilis
- ☐ Herpes Simplex
- ☐ Shingles
- ☐ None of the above