

# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Work Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_  
Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

## MEDICAL HISTORY:

Do you have allergies to any medications?  no  yes If yes, explain: \_\_\_\_\_

List all medications you take (excluding oral contraceptives, aspirin, over the counter medications and home remedies): \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

Please circle any of the following that you have had:

crossed eyes lazy eye drooping eyelids glaucoma retinal disease cataracts eye infections eye injury

If female, are you pregnant or nursing?  no  yes

Do you wear glasses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  no  yes If yes, how old is your present pair of contact lenses? \_\_\_\_\_

Type of contact lenses:  rigid  soft  extended wear  other Are they comfortable? \_\_\_\_\_

## REVIEW OF SYMPTOMS:

Do you currently have or do you chronically suffer from problems in any of the following areas?

### EYES

Loss of Vision / Side Vision	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Blurry Vision	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Distorted Vision / Halos	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Double Vision	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Dryness	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Mucous Discharge	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Redness	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Sandy or Gritty Feeling	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Itching	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Burning	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Foreign Body Sensation	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Excess Tearing / Watering	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Glare / Light Sensitivity	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Eye Pain or Soreness	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Chronic Infection of Eye or Lid	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Sties or Chalazion	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Flashes / Floaters in Vision	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Tired Eyes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure

### ENDOCRINE

Thyroid / Other Glands  no  yes  not sure

### CONSTITUTIONAL

Fever, Weight Loss/Gain  no  yes  not sure

### NEUROLOGICAL

Headaches  no  yes  not sure  
Migraines  no  yes  not sure  
Seizures  no  yes  not sure

### EARS, NOSE, MOUTH, THROAT

Allergies / Hay Fever	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Sinus Congestion	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Chronic Cough	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Dry Throat / Mouth	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure

### RESPIRATORY

Asthma	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Chronic Bronchitis	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Emphysema	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure

### VASCULAR / CARDIOVASCULAR

Diabetes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Heart Pain	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
High Blood Pressure	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Vascular Disease	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure

### GASTROINTESTINAL

	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
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### GENITOURINARY

Genitals / Kidneys / Bladder  no  yes  not sure

### BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
Muscle or Joint Pain	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure

### LYMPHATIC / HEMATOLOGIC

Anemia or Bleeding Problems	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
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### INTEGUMENTARY (SKIN)

	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
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### ALLERGIC / IMMUNOLOGIC

	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
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### PSYCHIATRIC

	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> not sure
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If you answered YES to any of the above or have a condition not listed, please explain: \_\_\_\_\_

