## Medical History Questionnaire

Date: ____/____/_____

Name: _____ Spouse or Parent Name: _____
Address: _____City: _____ State: _____Zip:_____
Employer: _____Occupation: _____Work Phone: _____E-Mail:_____
Vision Insurance: _____ Responsible Party for Services: _____
Birth Date: ____/____/_____ Social Security #:____/____/_____ Last Eye Exam: ____/____/_____
Name of Family Physician: _____Last Exam: ____/____/_____

**Medical History**

Do you have any allergies to medications?: _____No _____Yes If yes, please explain:_____

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List any medications you take (including aspirin, oral contraceptives, over the counter medications and home remedies;

_____

List all major injuries, surgeries and hospitalizations that you have had: _____
Are you pregnant or nursing? ____ No ___ Yes
Do you wear glasses? ____ No ____ Yes If Yes, age of lenses? _____
Do you wear contacts? ____ No ____ Yes If Yes, how old are your lenses? _____
Type of contact lenses: ___Rigid ___Soft ____Extended Wear ____Disposable

**Social History** (This history is kept strictly confidential. However, you may discuss this portion directly with the doctor, if you prefer. ____ Yes, I would prefer to discuss directly with the doctor.

Do you use tobacco products: ____No ____Yes If yes, type/amount/how long? _____
Do you drink alcohol?: ____No ____Yes If yes, type/amount/how long? _____
Do you use illegal drugs: ____No ____Yes If yes, type/amount/how long? _____

**Review of Systems**

Do you or any family member have or have had any of the following?

| Condition | Yes | No | Explain |
|---|---|---|---|
| Eye Injury or Surgery | | | |
| Loss of Vision | | | |
| Vision Disturbance (Spots, Flashes, Halos) | | | |
| Glaucoma | | | |
| Macular Degeneration | | | |
| Cataract | | | |
| Diabetic Retinopathy | | | |
| Amblyopia i.e. Lazy Eye | | | |
| Eye Turn | | | |
| Constitutional (Fever, Weight Loss) | | | |
| Ears, Nose, Throat (Sinus, Chronic Cough, etc.) | | | |
| Respiratory (Asthma, Emphysema, etc.) | | | |
| Cardiovascular (Hypertension, Stroke, Heart Attack, etc. | | | |
| Gastrointestinal | | | |
| Genitourinary (STD, Herpes, Chlamydia, Gonorrhea | | | |
| Muscles/Bones/Joints (Arthritis, etc.) | | | |
| Endocrine (Diabetes, Thyroid, etc.) | | | |
| Psychiatric (Depression, Anxiety, etc.) | | | |
| Blood/Lymph (Anemia, Cholesterol, Blood Disorder, etc.) | | | |
| Allergic/Immunologic (Hay Fever, Lupus, etc.) | | | |
| Skin (Rash, Eczema, etc.) | | | |
| Neurological (Headaches, MS, Stroke, etc.) | | | |
| Cancer | | | |

***I am responsible for payment at the time of each visit for all services provided by the Doctor not covered by an insurer. My signature serves as a 'signature on file' for claim processing and for the release of medical information to my insurance carrier(s).***

Signature:_____Date:_____