MEDICAL HISTORY QUESTIONNAIRE

Patient's Name (Please Print) _____ Today's Date _____

Birthday: _____ SSN: _____ - _____ - _____

Marital status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

Employer: _____ Occupation: _____

If Student: School: _____ Grade: _____

Racial Background: ☐American Indian or Alaska Native ☐ Asian ☐Black or African American ☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐White/Caucasian

Primary Care Physician: _____ Primary Pharmacy: _____

What is your primary reason for today's visit? _____

Are you interested in wearing Contact Lenses? ☐ Yes ☐ No Why? _____

Are you interested in Laser Vision Correction (LASIK)? ☐ Yes ☐ No Why? _____

MEDICATIONS List any medications you are currently taking:

Systemic Medications (Prescribed) ☐ None

_____

_____

_____

_____

Systemic Medications (Over-the-Counter) ☐ None

_____

_____

_____

_____

Eye Medications/Drops (Prescribed) ☐ None

_____

_____

Eye Medications/Drops (Over-the-Counter) ☐ None

_____

_____

Do you have any allergies to medications? If yes, please list: _____

_____

Do you need a refill of your Eye Medications/Drops? If yes, please list: _____

_____

OCULAR SYMPTOMS Do you currently experience any of the following symptoms?

Blurred Vision	☐ Yes	☐ No	Eye Pain or Soreness	☐ Yes	☐ No
Distorted Vision/Halos	☐ Yes	☐ No	Redness	☐ Yes	☐ No
Double Vison	☐ Yes	☐ No	Itching	☐ Yes	☐ No
Flashes of Light	☐ Yes	☐ No	Burning/Dryness	☐ Yes	☐ No
Floaters in Vision	☐ Yes	☐ No	Sandy or Gritty Sensation	☐ Yes	☐ No
Chronic Eyelid Inflammation	☐ Yes	☐ No	Excess Tearing/Watering	☐ Yes	☐ No
Stye or Chalazion	☐ Yes	☐ No	Other: _____		

PERSONAL OCULAR HISTORY Have you ever had any of the following eye conditions?

Cataract	☐ Yes	☐ No	Eye injury	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Strabismus (Crossed Eyes)	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No	Other: _____		

(Please turn over)

PERSONAL OCULAR SURGERY HISTORY Have you ever had any of the following eye surgeries?

Cataract surgery	☐ Yes	☐ No	Retinal Detachment Surgery	☐ Yes	☐ No
Glaucoma Surgery	☐ Yes	☐ No	Eye Muscle Surgery	☐ Yes	☐ No

Other:_____

PERSONAL MEDICAL HISTORY Have you ever had any of the following medical conditions?

Allergies	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Rosacea	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Elevated Cholesterol	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Other:_____		

FAMILY HISTORY (Parents, grandparents, siblings, children)

Cardiovascular Disease	☐ Yes	☐ No	Family Member(s):_____
Diabetes	☐ Yes	☐ No	Family Member(s):_____
High Blood Pressure	☐ Yes	☐ No	Family Member(s):_____
Cataract	☐ Yes	☐ No	Family Member(s):_____
Glaucoma	☐ Yes	☐ No	Family Member(s):_____
Macular Degeneration	☐ Yes	☐ No	Family Member(s): _____

Other:_____

PERSONAL SOCIAL HISTORY (Age 13 and older)

Have you ever used tobacco products? ☐ Current user ☐ Former user ☐ Never used

If a current or former user: ☐Cigarettes ☐ Cigars ☐Pipe ☐Smokeless Tobacco

Do you use alcohol? ☐ Yes ☐ No ☐ Social use only Do you use narcotics? ☐ Yes ☐ No

I was referred by:

☐ Another family Member: _____ **☐ A Friend or Co-Worker:**_____

☐ Another Doctor:_____ **☐ Insurance Plan**

This information is confidential and will be kept with your medical record and used only in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Thank you for assisting us in providing you with the very best eye health and vision care.