

Winters Eyecare

MEDICAL HISTORY QUESTIONNAIRE

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

Birthday: _____ SSN: _____ - _____ - _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

Email: _____

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 Vision 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: _____

(Please turn over)

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: _____

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: _____