

## Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
e-mail address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Guardian (If Applicable): \_\_\_\_\_ Birth Date: \_\_\_\_\_  
How did you find us / Referred by: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Name of Medical Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

**Medical History:** Last medical examination?: \_\_\_\_\_

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

List any medications (including oral contraceptives, aspirin, over the counter medications and home remedies or nutraceuticals (vitamins, herbal supplements) you take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Circle any of the following conditions that relate to you:

dry eye, Sjögren's syndrome, crossed eyes, lazy eye, Graves' disease, drooping eyelid, glaucoma, retinal disease, cataracts, macular degeneration, uveitis, eye infections, or eye injuries

Are you pregnant and/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 lenses? \_\_\_\_\_

Type of contact lenses:  rigid  soft  extended wear  other Are they comfortable?  no  yes

### Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased?) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____				_____

**Social History** *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive?  no  yes If yes, type / amount / how many hours per day: \_\_\_\_\_

Do you use a computer?  no  yes If yes, type / amount / how many hours per day: \_\_\_\_\_

Do you smoke?  no  yes If yes, how much? \_\_\_\_\_ how long? \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type / amount / how often: \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type / amount / how often: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**Review of Systems**

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
<b>CONSTITUTIONAL</b>				<b>EARS, NOSE, MOUTH, THROAT</b>			
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines / with aura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>				<b>RESPIRATORY</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VASCULAR / CARDIOVASCULAR</b>			
Burning or Stinging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES / JOINTS / MUSCLES</b>			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>				<b>LYMPHATIC / HEMATOLOGIC</b>			
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to any of the above or have a condition not listed, please explain & list medications:**

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\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date