

Medical and Ocular History Questionnaire

Name: _____ Today's Date ___/___/___

Birth Date: ___/___/___ Social Security # _____

Reason for Today's Visit? _____

Who was your last eye doctor? _____ When was your last eye exam? _____

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

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

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

What care system do you use? _____

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

	NO	YES		NO	YES
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Pain in eyes in darkened room	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	Frequently bump into objects	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Night reflection problems	<input type="checkbox"/>	<input type="checkbox"/>	Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by excessive weight of glasses	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>

**Have You or a family member had any of the following ocular conditions:
(please note parents, grandparents, siblings, children: living or deceased)**

DISEASE / CONDITION	NO	YES	?	MYSELF	RELATIVE
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE COMPLETE THE FOLLOWING SO THAT WE MAY BETTER ASSESS YOUR VISUAL NEEDS

Do you participate in any of the following?

<u>OCCUPATIONAL</u>	<u>SPORTS</u>	<u>HOBBIES</u>
— Protective Frame or Lenses	— Swimming	— Music
— Middle Viewing Distance	— Tennis	— Needlework
— Double Segment Bifocals	— Fishing	— Gardening
— Computers	— Boating	— Card Playing

Please Complete Backside

Social History This information is kept strictly confidential.

However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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: _____

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

Personal Physician: _____ Date of Last Exam: _____ Phone #: _____

Have you or a family member had any of the following medical conditions:

(please note parents, grandparents, siblings, children: living or deceased)

DISEASE / CONDITION	NO	YES	?	MYSELF	RELATIVE
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

List all medications you take including vitamins & supplements:

If you have a list of medications with you, please have our office staff copy and attach.

Medication Name	Taken for	Dosage	Medication Name	Taken for	Dosage
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List all major injuries, surgeries and / or hospitalizations you have had? _____

Are you pregnant and / or nursing? no yes

List any allergies or drug sensitivities and explain? _____

REVIEW OF SYSTEMS

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

SYSTEM	NO	YES		NO	YES
CONSTITUTIONAL			EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Genitals / Kidney/ Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR / CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
			Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL			LYMPHATIC / HEMATOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you have any medical condition not listed, please explain;

Date

Patients Signature

Doctors Signature