**Medical History Questionnaire**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

Marital Status: *Single  Married Widowed Divorced* SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 D

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Medical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Vision Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Medications are you taking (or provide a list)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medications?  No  Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries you have had (Cataract, Tonsillectomy, Appendectomy, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant and / or nursing? No Yes

Do you wear glasses?  No  Yes If yes, how old are your lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses  No  Yes If yes, how old is your current pair of lenses? \_\_\_\_\_\_\_\_\_\_

Brand / type of contact lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are they comfortable?  No  Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES PLEASE EXPLAIN.

|  |  |  |  |
| --- | --- | --- | --- |
| **EYES (Glaucoma, Cataract, etc.)** | **YES** | **NO** |  **EXPLAINATION OF PROBLEM** |
| Loss of vision  |  |  |  |
| Blurred Vision |  |  |  |
| Floaters |  |  |  |
| Fluctuation Vision |  |  |  |
| Distorted Vision (Halos) |  |  |  |
| Loss of Side Vision |  |  |  |
| Double Vision |  |  |  |
| Dryness of Eyes |  |  |  |
| Mucous Discharge |  |  |  |
| Redness |  |  |  |
| Sandy or Gritty feeling |  |  |  |
| **EYES** | **YES** | **NO** |  **EXPLANATION OF PROBLEM** |
| Itchy or Burning  |  |  |  |
| Foreign Body Sensation |  |  |  |
| Excess Tearing or Watering |  |  |  |
| Glare or Light Sensitivity  |  |  |  |
| Eye Pain or Soreness |  |  |  |
| Infection of Eye or Lid |  |  |  |
| Tired Eyes |  |  |  |
| Crossed Eyes, Lazy Eye |  |  |  |
| Drooping |  |  |  |

**Check Any Conditions Past or Present**

* Acne  Lupus  Pancreatitis
	+ Eczema Multiple Sclerosis  Crohn’s
	+ Psoriasis  Fibromyalgia  Colitis
	+ Rosacea  Sjogren Syndrome  Irritable Bowel Syndrome
	+ Skin Cancer  Cancer  Inflammatory Bowel Disease
	+ Seasonal Allergies  Heart Disease  Gall Bladder Dysfunction
	+ Allergic Rhinitis  Stroke Ankylosing Spondilitis
	+ Chronic Sinusitis  Hypertension  Hepatitis
	+ Hearing Loss High Cholesterol Liver Disease
	+ Asthma  Diabetes Type 1 Kidney Problems
	+ Pneumonia Diabetes Type 2  Parkinson’s Disease
	+ Emphysema  Insulin Dependent  Alzheimer’s Disease
	+ Sleep Apnea Hypothyroidism  Dementia
	+ Arthritis  Hyperthyroidism  Seizure Disorder/ Epilepsy
	+ Rheumatoid Arthritis  Gastro Esophageal Reflux  COPD
	+ Migraines  Cold sores  HIV
	+ Shingles  Headaches  Depression
	+ Anxiety Other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you previously been diagnosed with any of the following eye conditions?**

* None Other eye condition, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Glaucoma
* Cataract Surgery If yes, Name of Surgeon and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Macular Degeneration
* Retinal Detachment
* Amblyopia/ Lazy Eye if yes, which eye: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Eye Injury or Head Trauma If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **FAMILY HISTORY M = MOTHER F = FATHER B = BROTHER S = SISTER GP = GRANDPARENT** |
| **DISEASE** | **YES** | **NO** | **RELATIONSHIP TO PATIENT** |
| Arthritis |  |  |  |
| Stroke |  |  |  |
| Cancer |  |  |  |
| Diabetes, Type 2 |  |  |  |
| Diabetes Type 1 |  |  |  |
| Hypertension |  |  |  |
| Hyperthyroid  |  |  |  |
| Hypothyroid |  |  |  |
| Cataract  |  |  |  |
| Macular Degeneration |  |  |  |
| Glaucoma |  |  |  |
| Blindness |  |  |  |

**Social History**

Do you drive?  No  Yes

Do you have visual difficulty when driving?  No  Yes

Do you have problems with night vision?  No  Yes

Do you drink alcohol?  No  Yes

Do you use tobacco products? ** No if no, please choose from the following:**

  Former smoker

  Never a smoker

 ** Yes if yes, please choose from the following:**

  Smokes cigarettes  Current every day smoker

  Smokes cigars  Current some day smoker

  Smokes pipe  Heavy tobacco smoker

  Smokes other  Light tobacco smoker

  Uses smokeless tobacco

Have you ever had a blood transfusion?  No  Yes

Doctors Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_