

MEDICAL HISTORY QUESTIONNAIRE & REGISTRATION

Today's Date: _____

Name: _____ M F Spouse: _____

Social Security Number: _____ Date of Birth: _____ Last Eye Exam: _____

Parents' Name(s) (if minor) _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Place of Employment: _____ Work Phone: _____

Name of Medical Doctor: _____ Last Medical Exam: _____

Insurance: _____ **PLEASE SHOW US YOUR INSURANCE CARD(S)**

Subscriber: _____ DOB: _____ SSN: _____

MEDICAL HISTORY

ALLERGIES: None Penicillin Sulfa Aspirin Opioids Latex Other: _____

PLEASE SHOW US A LIST OF CURRENT MEDICATIONS OR List Medications (including over-the-counter vitamins, etc.)

List any major injuries, surgeries and/or hospitalizations you have had: _____

Circle any of the following that you have had: glaucoma, retinal disease, cataracts, crossed eyes, lazy eye, prominent eyes, drooping eyelid, eye infections or eye injury: _____

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

Do you wear contact lenses? Yes No If yes, how old is your present pair of lenses? _____

Type of contact lenses: Soft Gas Perm Disposable Extended Are you pregnant or nursing? Yes No

FAMILY HISTORY Please note any Family History (parents, grandparents, siblings; living or deceased):

Disease / Condition		Relationship to you
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Retinal Disease/Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No ?	_____

Name: _____

SOCIAL HISTORY (This information is kept strictly confidential; however, you may discuss this portion directly with your doctor, if you prefer.)

Do you drive? Yes No If yes, do you have difficulty seeing when driving? Yes No

Do you use tobacco? Yes No Cigarettes Cigars Smokeless Tobacco

Amount / How often? / How long? _____

Former smoker? How long since you quit? _____ Never smoked

Do you drink alcohol? Yes No If yes, Type/Amount/How long? _____

REVIEW OF SYSTEMS Do you currently, or have you ever had any significant problems in the following areas?:

Constitutional

Fever, Weight Loss/Gain Yes No ?
Cancer Yes No ?
Developmental Disabilities Yes No ?
HIV Yes No ?

Ears, Nose, Mouth, Throat

Hearing Loss Yes No ?
Allergies / Hay Fever Yes No ?
Sinus Congestion Yes No ?
Runny Nose / Post-Nasal Drip Yes No ?
Chronic Cough Yes No ?
Dry Throat / Mouth Yes No ?

Neurological

Headaches / Migraines Yes No ?
Stroke / CVA Yes No ?
Seizures Yes No ?

Psychiatric

Depression Yes No ?
Anxiety Yes No ?
ADHD Yes No ?

Cardiovascular

High Blood Pressure Yes No ?
Congestive Heart Failure Yes No ?
Heart Pain Yes No ?
Vascular Disease Yes No ?

Respiratory

Asthma Yes No ?
Chronic Bronchitis Yes No ?
Emphysema Yes No ?
Sleep Apnea Yes No ?

Gastrointestinal

Ulcer Yes No ?
Acid Reflux Yes No ?
Chronic Diarrhea Yes No ?
Chronic Constipation Yes No ?

Genitourinary

Benign Prostatic Hypertrophy Yes No ?
Hepatitis Yes No ?
Bladder / Kidney Disease Yes No ?
Herpes / STD Yes No ?

Bones / Joints / Muscles

Rheumatoid Arthritis / Arthritis Yes No ?
Osteoporosis Yes No ?
Gout Yes No ?
Fibromyalgia Yes No ?

Integumentary (Skin)

Eczema Yes No ?
Shingles Yes No ?
Psoriasis Yes No ?

Endocrine

Diabetes: Type 1 Type 2 Yes No ?
Thyroid Dysfunction Yes No ?
Hormonal Dysfunction Yes No ?

Lymphatic / Hematologic

High Cholesterol Yes No ?
Anemia Yes No ?
Bleeding Problems Yes No ?

Allergy / Immunologic

Lupus Yes No ?

Eyes

Loss of Vision / Loss of Side Vision Yes No ?
Blurred Vision Yes No ?
Distorted Vision / Halos Yes No ?
Double Vision Yes No ?
Dryness Yes No ?
Mucous Discharge Yes No ?
Redness Yes No ?
Sandy / Gritty Feeling Yes No ?
Itching / Burning Yes No ?
Foreign Body Sensation Yes No ?
Excess Tearing / Watering Yes No ?
Glare / Light Sensitivity Yes No ?
Eye Pain or Soreness Yes No ?
Chronic Infection of Eye / Eyelid Yes No ?
Stye or Chalazion Yes No ?
Flashes of Light Yes No ?
Floaters in Vision Yes No ?
Tired Eyes / Eye Strain Yes No ?

Other _____

Other _____