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:_____

Language: ☐English ☐Other_____ Race: ☐White ☐African American ☐Other_____

Ethnicity: ☐Non-Hispanic/Non-Latino ☐Hispanic/Latino ☐African American ☐Other_____

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: ☐Penicillin ☐Sulfa ☐Aspirin ☐Codeine ☐Iodine ☐Latex Other:_____

List Current Medications (including over-the-counter medications, vitamins, etc.) or **SHOW US A LIST OF MEDICATIONS**

_____

_____

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	☐Yes	☐No	?	
Cataract	☐Yes	☐No	?	
Crossed Eyes	☐Yes	☐No	?	
Glaucoma	☐Yes	☐No	?	
Macular Degeneration	☐Yes	☐No	?	
Retinal Disease/Detachment	☐Yes	☐No	?	
Diabetes	☐Yes	☐No	?	
Heart Disease	☐Yes	☐No	?	
High Blood Pressure	☐Yes	☐No	?	
Cancer	☐Yes	☐No	?	
Thyroid Disease	☐Yes	☐No	?	
Lupus	☐Yes	☐No	?	
Other _____	☐Yes	☐No	?	

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 ?