EHR Number_____________
DOB___________________

Medical History Questionnaire

Today's Date / /	Last Eye Exam / /
Name:	
Birth Date: / /	Age
Cell Phone Number	Home phone
Email address *(For appt confirmations, discounts in the Optical shop, weather related announcements)*	
Name of your primary care doctor (PCP):	Date of Last Medical Exam
Phone number of PCP	Reason for last medical exam
Address of your PCP	

ALLERGIES

Do you have any ALLERGIES to **medications**? ❑Yes ❑ No If yes, please list:

Are you immuno-compromised?

Do you have an active cough?	❑Yes ❑ No	
Are you undergoing chemotherapy?	❑Yes ❑ No	
Do you have an AIDS diagnosis?	❑Yes ❑ No	
Do you have TB?	❑Yes ❑ No	
Do you have Hepatitis?	❑Yes ❑ No	❑ A ❑ B ❑C

Female Patients only

Are you pregnant and/or nursing?	❑Yes ❑No	Date of LMP
Estimated date of Delivery?		

Do you wear Contact Lenses?	❑Yes ❑No.
If yes, how old are your present lenses?	
Type of Contacts:	
❑RGP ❑Daily Wear ❑Extended Wear ❑Bifocal ❑ Monovision ❑ Other	
Are the lenses comfortable?	❑Yes ❑ No. Please list the Brand:
Are you interested in LASIK surgery?	❑ Yes ❑ No

Current Eye History

Please tell us the reason for your visit today:

- ❑ Change in vision
- ❑ My annual check up
- ❑ Difficulty with seeing far away
- ❑ Difficulty with seeing up close
- ❑ Injury to the eye
- ❑ Pain in my ❑ left eye or ❑ right eye
- ❑ My Primary Care doctor told me to make an appointment
- ❑ I am a diabetic and was referred by my doctor
- ❑ I have a diagnosis of glaucoma and it's time to be seen again
- ❑ Other:

Do you currently or have you had?		Please provide details if your answer is Yes
Loss of Vision	❑Yes ❑ No	
Blurred Vision	❑Yes ❑ No	❑ Near ❑ Far
Distorted Vision	❑Yes ❑ No	❑ wavy lines ❑ black spots ❑ halos
Loss of Side Vision	❑Yes ❑ No	
Double Vision	❑Yes ❑ No	
Dryness	❑Yes ❑ No	
Mucous Discharge	❑Yes ❑ No	
Redness	❑Yes ❑ No	
Sandy or Gritty Feeling	❑Yes ❑ No	
Itching	❑Yes ❑ No	
Burning	❑Yes ❑ No	
Foreign Body Sensation	❑Yes ❑ No	
Excess Tearing / Watering	❑Yes ❑ No	
Glare/ Light Sensitivity	❑Yes ❑ No	
Eye Pain or Soreness	❑Yes ❑ No	
Possible or known infection in your eye?	❑Yes ❑ No	
Sty or Chalazion	❑Yes ❑ No	
Floaters/flashes in vision	❑Yes ❑ No	
Tired Eyes	❑Yes ❑ No	
Have you been told you might have Glaucoma?	❑Yes ❑ No	
Are you a diabetic?	❑Yes ❑ No	
Have you been told you have a cataract?	❑Yes ❑ No	

Review Of Systems

Do you currently, or have you had, problems in the following areas:			
Constitutional		**Vascular / Cardiovascular**	
Fever	❑ Yes ❑ No	Heart Pain	❑ Yes ❑ No
Weight Loss/ Gain	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Integumentary (Skin)		High Cholesterol	❑ Yes ❑ No
Shingles	❑ Yes ❑ No	Vascular Disease	❑ Yes ❑ No
Rosacea	❑ Yes ❑ No	**Gastrointestinal**	
Rashes	❑ Yes ❑ No	Diarrhea	❑ Yes ❑ No
Neurological		Constipation	❑ Yes ❑ No
Headaches	❑ Yes ❑ No	Nausea	❑ Yes ❑ No
Migraines	❑ Yes ❑ No	Vomiting	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	**Genitourinary**	
Numbness	❑ Yes ❑ No	Bladder/kidney infection	❑ Yes ❑ No
Weakness	❑ Yes ❑ No	Kidney stones	❑ Yes ❑ No
Tingling	❑ Yes ❑ No	Urinary frequency	❑ Yes ❑ No
Cognitive Impairment	❑ Yes ❑ No		
Endocrine		**Bones/ Joints/ Muscles**	❑ Yes ❑ No
Hyperthyroidism	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Hypothyroidism	❑ Yes ❑ No	Muscle Pain	❑ Yes ❑ No
Diabetes Type 1	❑ Yes ❑ No	Joint Pain	❑ Yes ❑ No
Diabetes Type 2	❑ Yes ❑ No		
Ears, Nose, Mouth, Throat		**Lymphatic/ Hematologic**	
Allergies / Hay Fever	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
Sinus Congestion	❑ Yes ❑ No	Bleeding Problems	❑ Yes ❑ No
Runny Nose	❑ Yes ❑ No		
Post-Nasal Drip	❑ Yes ❑ No	**Psychiatric**	
Dry Throat / Mouth	❑ Yes ❑ No	ADHD	❑ Yes ❑ No
Respiratory		Anxiety	❑ Yes ❑ No
Chronic Cough	❑ Yes ❑ No	Bipolar	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No	Depression	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Schizophrenia	❑ Yes ❑ No
Chronic Bronchitis	❑ Yes ❑ No		
Emphysema	❑ Yes ❑ No	**Other**	❑ Yes ❑ No

Reviewed by: ________ Date_________

Past Medical and Family Medical and Ocular History

In the first three columns: Please indicate if you have any of the following conditions:

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

Disease/ Condition	YOU ☑	YES ☑	Treatment	Family Member *State the relationship Mother, father, child etc*	YES ☑	Treatment
Blindness						
Cataracts						
Crossed Eyes/Strabismus						
Glaucoma						
Macular Degeneration						
Retinal Detachment /Disease						
Rheumatoid Arthritis						
Cancer: Type:						
Dry Eye						
Diabetes						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Lupus						
Thyroid Disease						
Neurological disorders						
Depression						
Other						

Please list any major surgeries and/or hospitalizations :

Surgery	Date	Hospitalization Dates	Reason

Social History

Do you use tobacco products? ❑ Yes ❑ No How often?		
Do you use recreational drugs? ❑ Yes ❑ No If yes, list the type/ amount/ how long		
Do you drink alcohol? ❑ Yes ❑ No How much?		
Have you ever been exposed to, or infected with : ❑Gonorrhea	❑ Yes	❑ No
❑ Hepatitis	❑ Yes	❑ No
❑HIV	❑ Yes	❑ No
❑Syphilis	❑ Yes	❑ No
❑Toxoplasmosis	❑ Yes	❑ No

What is your occupation?

How many hours each day do you spend at the Computer or electronic devices ?

❑ none ❑1 to 2 hours ❑ 2.5 to 5 ❑5.5 to8 ❑more than 8

Do you play Sports: ❑ Baseball ❑Basketball ❑Bicycle ❑Bowling ❑Field Hockey ❑Fish ❑Football ❑ Golf ❑Gymnastics ❑Hunt ❑Ice Hockey ❑Ice Skating ❑Kayak/Canoe ❑Racquet Ball ❑ Roller Skate ❑Run/Marathons ❑Rugby ❑Shoot (trap, rifle range, Skeet) ❑Skate Board ❑Ski ❑Snowboard ❑ Soccer ❑Softball ❑Squash ❑Swim ❑Tennis ❑Other
Please list your hobbies:
Please list your crafts: *(such as: scrapbooking, rug hooking, embroidery, sewing)*
Do you read for pleasure? ❑Yes ❑ No How many books in a week?

Medications

Please list all medications you are presently taking and the strength of the medication as well as the number of times a day you take the medication. If you have a list, please present it to be photocopied.
Please include oral contraceptives, aspirin, Over The Counter medications, home remedies, and vitamin supplements

EYE Medications	Dose	Number of per Times/Day:	How long have you taken this drug

All other Medications	Dose	Number of per Times/Day:	How long have you taken this drug

Pharmacy Information

Name
Address
Phone

Patient Name	**Date**	
Date of Birth	**EHR #**	**Acct #**