Medical History Questionnaire

Patient Name:____Today's Date:__________/_________/ ________

Address: ____ Home Phone: __________________________

City:_________________________Zip: ______________ Cell Phone:______________________text OK?YN

Birth Date:______/______/______Social Security #:_____/_____/ _____ Occupation: _________________________

Name of Medical Doctor: _________________________City:__________ Last Eye Exam:________/_________/ _________

Vision Insur:_______________________________

E-mail: _________________________@_________________________ Guar. DOB:___/___/ ___ & Last 4 social:_________

Insurance Guarantor: ______________________________spouse/parent/other

Best to contact patient by: Cell Phone Email Text Other:_________________

PATIENT Medical History: For your medical record: Your height: ______ weight: _______ your blood pressure: _______/______

Do you have any allergies to medications? ☐ No ☐ Yes if yes, explain: ____

____

List any medications you take (including Latisse, oral contraceptives, aspirin, over the counter medications, vitamins and home remedies):

____

____

List all major injuries, surgeries, and /or hospitalizations you have had (including LASIK): ______________________________

____

____

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

Are you pregnant and/or nursing? ☐ no ☐ yes

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

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? ☐ yes ☐ no

FAMILY History:

Please check positive family history (parents, grandparents, Siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION YES, Who?

- ☐ Blindness
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease Lupus
- ☐ Thyroid Disease

Other ____________________

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative: _________________________

If not referred, how did you choose our office?

- ☐ Another Doctor referral
- ☐ Saw Sign/Building
- ☐ Newspaper
- ☐ Web Page, Which Site? _________________
- ☐ ForesightOptometry.com
- ☐ Yelp
- ☐ Google
- ☐ VisionSource.com
- ☐ Other:___________________

*Please turn this form over or roll down and complete page two**

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

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

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

____

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 or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas? **Please check all that apply to you**

CONSTITUTIONAL
- ☐ Fever, Weight Loss/Gain

INTEGUMENTARY
- ☐ Skin

NEUROLOGICAL
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

EYES
- ☐ Loss of Vision
- ☐ Blurred Vision
- ☐ Distorted
- ☐ Vision/Halos
- ☐ Loss of Side Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Sandy or Gritty
- ☐ Feeling Itching
- ☐ Burning
- ☐ Foreign Body Sensation
- ☐ Excess Tearing/Watering
- ☐ Glare/Light Sensitivity Eye
- ☐ Pain or Soreness
- ☐ Chronic Infection of Eye or
- ☐ Lid Sties or Chalazion
- ☐ Flashes/Floaters in Vision
- ☐ Tired Eyes

ENDOCRINE
- ☐ Thyroid/Other Glands

CANCER YES ☐ NO ☐

If Yes, Type: ____________________

EARS, NOSE, MOUTH, THROAT
- ☐ Allergies/Hay
- ☐ Fever Sinus
- ☐ Congestion
- ☐ Runny Nose
- ☐ Post-Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

VASCULAR/CARDIOVASCULAR
- ☐ Diabetes
- ☐ Heart Pain
- ☐ High Blood Pressure
- ☐ Vascular Disease

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Constipation

GENITOURINARY
- ☐ Genitals/Kidney/Bladder

BONES/JOINTS/MUSCLES
- ☐ Rheumatoid
- ☐ Arthritis Muscle Pain
- ☐ Joint Pain

LYMPHATIC/HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding Problems

ALLERGIC/IMMUNOLOGIC
- ☐ **Allergies**

PSYCHIATRIC
- ☐ **Psychiatric**

If you circled any of the above or have a condition not listed, please explain below (and list medications on first page):

____

____

____

____

____

____ ______________________

Name Date