MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Last Eye Exam: _____ Drs Name _____

What is the primary reason you have come in today? _____

Are you interested in Laser Vision Correction? ○ no ○ yes

Name of Medical Dr. _____ Last Medical Exam: _____

Medical History

Do you have any allergies to medications? ○ no ○ yes If yes, explain: _____

_____

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

_____

_____

_____

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

_____

List any of the following that you have had: crossed eyes, 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 sunglasses? ○ no ○ yes If yes, are they prescription? ○ no ○ yes
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

List any WORK ACTIVITIES or HOBBIES that may require special visual needs (computer, sports, etc):

_____

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	○	○	○	_____
Cataract	○	○	○	_____
Crossed Eyes	○	○	○	_____
Glaucoma	○	○	○	_____
Macular Degeneration	○	○	○	_____
Retinal Detachment/Disease	○	○	○	_____
Arthritis	○	○	○	_____
Cancer	○	○	○	_____
Diabetes	○	○	○	_____
Heart Disease	○	○	○	_____
High Blood Pressure	○	○	○	_____
Kidney Disease	○	○	○	_____
Lupus	○	○	○	_____
Thyroid Disease	○	○	○	_____
Other _____	○	○	○	_____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the 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 to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
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	○	○	○

EARS, NOSE, MOUTH, THROAT	NO	YES	?
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	○	○	○
PSYCHIATRIC	○	○	○

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____ _____

Doctor's Signature Date