Medical History Questionnaire

Please carefully read and answer *all* questions on the following 6 pages, including Review of Systems.

Patient's First and Last Name: ____ Today's Date: ____/____/______

Birth Date: ____/____/______ Last Eye Exam: ____/____/______ Last Medical Exam: ____/____/______

Name of Medical Doctor: ____ Dr.'s Phone: ____________________________

Ocular History (*OCULAR* = relating to your eyes)

Have you ever had any of the following *eyes-related* conditions? Please check all that apply.

☐ Crossed Eyes ☐ Lazy Eye ☐ Drooping Eyelid ☐ Prominent Eyes ☐ Glaucoma ☐ Retinal Disease

☐ Cataracts ☐ Eye Infection ☐ Eye Injury ☐ Other (please specify): ____

____

Ocular Medications

Name any medications you take that are *applied to the eyes* (for example, some sort of medical eye drops): _________________

____

____

Do you have **allergies** to any *ocular* medications? ☐ Yes ☐ No If YES, explain briefly: ______________________________

____

____

Ocular Surgical History

List all major surgeries you have had on your eyes (for example, Glaucoma surgery):_________________________________

____

____

Medical History

List any major injures and/or hospitalizations you have had: ____

____

____

Have you ever been exposed or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis

Are you pregnant? ☐ Yes ☐ No Are you currently nursing? ☐ Yes ☐ No

Systemic Surgical History (*SYSTEMIC* = relating to organs or parts of your body other than your eyes)

List all major systemic surgeries you have had (for example, appendix removal): _____________________________________

____

____

Systemic Medications

Name any medications you take (*other than* eye/ocular medications), including oral contraceptives, aspirin, over-the-counter medications and home remedies: ____

____

____

Do you have **allergies** to any *systemic* medications? ☐ Yes ☐ No If YES, explain briefly: ____________________________

____

____

Ocula

Please n ... llowing *eyes-related* diseases or conditions:

DISEASE/CONDITION \ AFFECTED FAMILY MEMBER(S)	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Aunt	Uncle	Distant Relative
Blindness											
Cataract											
Crossed Eyes											
Glaucoma											
Macular Degeneration											
Retinal Detachment/Disease											
Other:											

Systen

Please n ... llowing diseases or conditions affecting organs or parts of the body (other than the eyes):

DISEASE/CONDITION \ AFFECTED FAMILY MEMBER(S)	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Aunt	Uncle	Distant Relative
Arthritis											
Cancer											
Diabetes											
Heart Disease											
High Blood Pressure											
Kidney Disease											
Lupus											
Thyroid Disease											
Other:											

Social History

Do you drive? ☐ Yes ☐ No If YES, do you have visual difficulties when driving? ☐ Yes ☐ No If YES, please describe:

____

Do you smoke tobacco products? ☐ Yes ☐ No If YES, how many packs in average per day? ________________________

Have you smoked in the past? ☐ Yes ☐ No If YES, how many years ago did you stop smoking? _____________________

Do you drink alcohol? ☐ Yes ☐ No If YES: ☐ Social use ☐ 1-2 drinks/day ☐ Above average use ☐ Alc. dependence

Do you use narcotics? ☐ Yes ☐ No If YES: ☐ Recreational use ☐ Chemical dependence

Spectacle Status

Do you wear glasses? ☐ No ☐ Yes, specify type (distance, reading, bifocal, etc.): ____________________________________

If YES, how old is your present pair of lenses? _____________________

Contact Lens (CL) Status

Do you wear contact lenses? ☐ Yes ☐ No If YES, for how long have you had your current lens prescription?______________

CL Type: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other: __________________ Are they comfortable? ☐ Yes ☐ No

Review of Systems

Do you currently have, or have you ever had, any problems in the following areas? (If YES, please briefly explain symptoms and list medications.)

EYE	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
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	☐	☐	☐	
Other:	☐	☐	☐	

ALLERGIES	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Local Anesthetics	☐	☐	☐	
Anaphylactic Reactions	☐	☐	☐	
Animal Dander	☐	☐	☐	
Antibiotics	☐	☐	☐	
Aspirin	☐	☐	☐	
Cigarette Smoke	☐	☐	☐	
Cycloplegics	☐	☐	☐	
Dairy Products	☐	☐	☐	
Dust	☐	☐	☐	
Environmental	☐	☐	☐	
Foods	☐	☐	☐	
Fungi	☐	☐	☐	
Humidity	☐	☐	☐	
Molds/Mildew	☐	☐	☐	
Penicillin	☐	☐	☐	
Pollens	☐	☐	☐	
Preservatives	☐	☐	☐	
Shellfish	☐	☐	☐	
Steroids	☐	☐	☐	
Sulfa Drugs	☐	☐	☐	
Sun	☐	☐	☐	
Tetracyclines	☐	☐	☐	
Thimerosal	☐	☐	☐	
Yeast	☐	☐	☐	
Other:	☐	☐	☐	

INTEGUMENTARY (Skin)	NO	YES	Unsure	Explain Symptoms / Medications
Acne/Acne Rosacea	☐	☐	☐	
Atopic Dermatitis	☐	☐	☐	
Dermatitis/Contact Dermatitis	☐	☐	☐	
Dry Skin	☐	☐	☐	
Ocular Rosacea	☐	☐	☐	
Psoriasis	☐	☐	☐	
Sunburn	☐	☐	☐	
Warts	☐	☐	☐	
Other:	☐	☐	☐	
NEUROLOGICAL	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Bell’s Palsy	☐	☐	☐	
Brain Damage (Trauma)	☐	☐	☐	
Dyslexia	☐	☐	☐	
Epilepsy	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	
Myathenia Gravis	☐	☐	☐	
Nystagmus	☐	☐	☐	
Seizure Disorder	☐	☐	☐	
Other:	☐	☐	☐	
HEAD	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Chronic Cough	☐	☐	☐	
Dental Disorder	☐	☐	☐	
Dry Mouth	☐	☐	☐	
Ear Infection	☐	☐	☐	
Headaches	☐	☐	☐	
Migraine	☐	☐	☐	
Hearing Loss	☐	☐	☐	
Sinusitis (Sinus Infection/Congestion)	☐	☐	☐	
Other:	☐	☐	☐	
RESPIRATORY	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Asthma	☐	☐	☐	
Bronchitis	☐	☐	☐	
Cancer: Lung	☐	☐	☐	
Emphysema	☐	☐	☐	
Respiratory Dysfunction	☐	☐	☐	
Smoker (Heavy)	☐	☐	☐	
Tuberculosis	☐	☐	☐	
Other:	☐	☐	☐	
CARDIOVASCULAR	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Cardiovascular Disease	☐	☐	☐	
Elevated Cholesterol	☐	☐	☐	
Hypertension (High Blood Pressure)	☐	☐	☐	
Mitral Valve Prolapse	☐	☐	☐	
Stroke	☐	☐	☐	
Heart Trouble	☐	☐	☐	
Other:	☐	☐	☐	

GASTROINTESTINAL	NO	YES	Unsure	Explain Symptoms / Medications
Acid-Reflux Syndrome	☐	☐	☐	
Cancer: Colon	☐	☐	☐	
Cancer: Liver	☐	☐	☐	
Diarrhea	☐	☐	☐	
Diverticulosis	☐	☐	☐	
Gall Bladder	☐	☐	☐	
Hepatitis	☐	☐	☐	
Inflammatory Bowel	☐	☐	☐	
Constipation	☐	☐	☐	
Other:	☐	☐	☐	
GENITOURINARY	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Bladder Infections	☐	☐	☐	
Menopause	☐	☐	☐	
Prostate Cancer	☐	☐	☐	
Sexually Transmitted Disease	☐	☐	☐	
Other:	☐	☐	☐	
MUSCULOSKELETAL	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Ankylosing Spondylitis	☐	☐	☐	
Arthritis	☐	☐	☐	
Arthritis: Rheumatoid	☐	☐	☐	
Myasthenia Gravis	☐	☐	☐	
Joint Pain	☐	☐	☐	
Muscle Pain	☐	☐	☐	
Other:	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Anemia	☐	☐	☐	
Leukemia	☐	☐	☐	
Sickle Cell Disease	☐	☐	☐	
Bleeding Easily	☐	☐	☐	
Other:	☐	☐	☐	
ENDOCRINE	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Crohn’s Disease	☐	☐	☐	
Diabetes Mellitus	☐	☐	☐	
Thyroid Disorder	☐	☐	☐	
Other:	☐	☐	☐	
PSYCHIATRIC	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Alcoholism	☐	☐	☐	
Alzheimer’s Disease	☐	☐	☐	
Anxiety Disorder	☐	☐	☐	
Bi-Polar Disorder	☐	☐	☐	
Depression	☐	☐	☐	
Drug Dependency (Current)	☐	☐	☐	
Drug Dependency (Past)	☐	☐	☐	
Learning Disability	☐	☐	☐	
Mood Disorder	☐	☐	☐	
Other:	☐	☐	☐	

CONSTITUTIONAL	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
Car Sickness	☐	☐	☐	
Dizziness	☐	☐	☐	
Thirst Excess	☐	☐	☐	
Urination Excess	☐	☐	☐	
Weight Gain	☐	☐	☐	
Weight Loss	☐	☐	☐	
Other:	☐	☐	☐	
IMMUNOLOGICAL	**NO**	**YES**	**Unsure**	**Explain Symptoms / Medications**
AIDS	☐	☐	☐	
Herpes Simplez	☐	☐	☐	
HIV Positive	☐	☐	☐	
Tuberculosis	☐	☐	☐	
Other:	☐	☐	☐	

~ Thank you ~

Please let us know if you have any questions. We are here to serve you!

_______________________________________ _____________________

Patient's Signature Date

_______________________________________ _____________________

Dr. Luelinda Tomlin's Signature Review Date

Form Last Updated: 1/2/2014
By: Karoline Ahnefeld, EyeTcare