

Medical History Questionnaire

Important: This questionnaire is to be reviewed at each appointment. Please print and answer all questions.

Name: _____ Today's Date: ____/____/____
Address: _____ Phone: _____
Work Phone: _____
E-mail address: _____ Referred by: _____
Guardian (if applicable): _____ Occupation: _____
Birth date: ____/____/____ Social Security #: ____/____/____ Last eye exam: _____
Name of medical doctor: _____ Dr's Phone: _____

Medical History

Do you have any allergies to medications? No Yes Last medical exam: _____

If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): None _____

Are you pregnant and/or nursing? No Yes

List all major injuries, surgeries and/or hospitalizations you have had: None _____

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: None Rigid Soft Extended wear Other _____

Are your contact lenses comfortable? No Yes

History

Do you or any blood relatives (parents, grandparents, siblings, children, living or deceased) have the following conditions:

Disease/condition	No	Self	Family	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ Type _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you interested in Lasik surgery? Yes No If yes, when? _____

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

Yes, I prefer to discuss my social history 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 smoke? 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: None Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following area:

System	No	Yes	?		No	Yes	?
Constitutional				Ears, nose, mouth, throat			
Fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Respiratory			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/kidney/bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/joints/muscles			
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/hematologic			
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

I, _____, have read Broady Optometry's "notice of privacy practices".

Patient signature

Date

Doctor's signature

Date

Reviewed by _____
Reviewed by _____
Reviewed by _____

No changes Date _____
 No changes Date _____
 No changes Date _____