Linda R. Price, O.D.

MEDICAL HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name: ____ **Date:** ___/___/___

Date of Birth: ___/___/___ **Gender:** ______________________

Last Medical Exam: ___/___/___ **Dr.'s Name:** ______________________

Last Eye Exam: ___/___/___ **Dr.'s Name:** ______________________

Pharmacy Tel/Fax: ____

OCULAR/MEDICAL HISTORY

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: ______________________

____

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

____

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

____

Do you have or have you ever had?

☐ Glaucoma ☐ Lazy eye ☐ High Blood Pressure ☐ Diabetes

☐ Macular Degeneration ☐ Cross eye How long?________ How long? ________

☐ Cataracts ☐ Eye Injury ☐ High Cholesterol AIC: _____________

☐ Autoimmune Disease ☐ Eye Infection How long? ________ ☐ Cancer

☐ Other condition not listed: ___________________ ☐ Retinal Hole/Detach Type:

☐ Thyroid Disease ☐ Eye Surgery Date: ___/___/___ Type: ___________ Date: ___/___/___

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

Do you wear glasses? ☐ No ☐ Yes **How old?** ____________ **Comfortable to wear?** ☐ **No** ☐ **Yes**

Do you wear contacts? ☐ No ☐ Yes **How old?** ____________ **Comfortable to wear?** ☐ **No** ☐ **Yes**

Lens Type: ☐ Rigid ☐ Soft ☐ **Extended Wear** ☐ **Other:**______________

Previous Contact Lens RX: **Brand:** ____________________________ **Size:** _______________

Power, Right eye: _________________________ **Power, Left eye:** ____________________________

FAMILY HISTORY

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

CONDITION	No	Yes	Relation	CONDITION	No	Yes	Relation
Blindness:	☐	☐	__________	Cancer:	☐	☐	__________
Cataract:	☐	☐	__________	Diabetes:	☐	☐	__________
Crossed Eyes:	☐	☐	__________	Heart Disease:	☐	☐	__________
Macular Degeneration:	☐	☐	__________	High Blood Pressure:	☐	☐	__________
Retinal Detachment:	☐	☐	__________	Kidney Disease:	☐	☐	__________
Glaucoma:	☐	☐	__________	Multiple Sclerosis:	☐	☐	__________
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 like to discuss my Social History information directly with my doctor.

Do you use tobacco products? ☐ No ☐ Yes Type/Amount/How long: _________/ _________/ _________

Do you drink alcohol? ☐ No ☐ Yes Type/Amount/How long: _________/ _________/ _________

Do you use illegal drugs? ☐ No ☐ Yes Type/Amount/How long: _________/ _________/ _________

Do you drive? ☐ No ☐ Yes Visual difficulty when driving? ☐ No ☐ Yes

Have you been exposed/infected with: ☐ HIV ☐ Hepatitis ☐ Gonorrhea ☐ Syphilis ☐ Herpes

REVIEW OF SYSTEMS

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

CONSTITUTIONAL			
Fever:	☐ No	☐ Yes	☐ ?
Recent Weight Loss/Gain:	☐ No	☐ Yes	☐ ?
INTEGUMENTARY (Skin)			
Rash:	☐ No	☐ Yes	☐ ?
Itching:	☐ No	☐ Yes	☐ ?
Moles:	☐ No	☐ Yes	☐ ?
NEUROLOGICAL			
Headaches:	☐ No	☐ Yes	☐ ?
Migraines:	☐ No	☐ Yes	☐ ?
Seizures:	☐ No	☐ Yes	☐ ?
Dizziness:	☐ No	☐ Yes	☐ ?
Numbness/Tingling:	☐ No	☐ Yes	☐ ?
EYES			
Loss of Vision:	☐ No	☐ Yes	☐ ?
Blurred Far Vision:	☐ No	☐ Yes	☐ ?
Blurred Near Vision:	☐ No	☐ Yes	☐ ?
Distorted Vision/Halos:	☐ No	☐ Yes	☐ ?
Loss of Side Vision:	☐ No	☐ Yes	☐ ?
Double Vision:	☐ No	☐ Yes	☐ ?
Night Vision Problems:	☐ No	☐ Yes	☐ ?
Color Vision Problems:	☐ No	☐ Yes	☐ ?
Dryness:	☐ No	☐ Yes	☐ ?
Mucous Discharge:	☐ No	☐ Yes	☐ ?
Redness:	☐ No	☐ Yes	☐ ?
Sandy or Gritty Feeling:	☐ No	☐ Yes	☐ ?
Itching:	☐ No	☐ Yes	☐ ?
Burning:	☐ No	☐ Yes	☐ ?
Excess Tearing/Watering:	☐ No	☐ Yes	☐ ?
Glare/Light Sensitivity:	☐ No	☐ Yes	☐ ?
Eye Pain or Soreness:	☐ No	☐ Yes	☐ ?
Infection of Eye/Lid:	☐ No	☐ Yes	☐ ?
Foreign Body Sensation:	☐ No	☐ Yes	☐ ?
Sties or Chalazion:	☐ No	☐ Yes	☐ ?
Flashes of Vision:	☐ No	☐ Yes	☐ ?
Floaters in Vision:	☐ No	☐ Yes	☐ ?
ENDOCRINE			
Thyroid:	☐ No	☐ Yes	☐ ?
Diabetes:	☐ No	☐ Yes	☐ ?

EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever:	☐ No	☐ Yes	☐ ?
Sinus Congestion:	☐ No	☐ Yes	☐ ?
Runny Nose:	☐ No	☐ Yes	☐ ?
Post-Nasal Drip:	☐ No	☐ Yes	☐ ?
Chronic Cough:	☐ No	☐ Yes	☐ ?
Dry Throat/Mouth:	☐ No	☐ Yes	☐ ?
RESPIRATORY			
Asthma:	☐ No	☐ Yes	☐ ?
Emphysema:	☐ No	☐ Yes	☐ ?
Sleep Apnea:	☐ No	☐ Yes	☐ ?
VASCULAR/CARDIOVASCULAR			
Heart/Chest Pain:	☐ No	☐ Yes	☐ ?
High Cholesterol:	☐ No	☐ Yes	☐ ?
High Blood Pressure:	☐ No	☐ Yes	☐ ?
Vascular Disease:	☐ No	☐ Yes	☐ ?
GASTROINTESTINAL			
Diarrhea:	☐ No	☐ Yes	☐ ?
Constipation:	☐ No	☐ Yes	☐ ?
GENITOURINARY			
Kidney Stones:	☐ No	☐ Yes	☐ ?
Difficult Urination:	☐ No	☐ Yes	☐ ?
Incontinence:	☐ No	☐ Yes	☐ ?
Genital Problems:	☐ No	☐ Yes	☐ ?
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis:	☐ No	☐ Yes	☐ ?
Muscle Pain/Weakness:	☐ No	☐ Yes	☐ ?
Joint Pain/Weakness:	☐ No	☐ Yes	☐ ?
LYMPHATIC/HEMATOLOGIC			
Anemia:	☐ No	☐ Yes	☐ ?
Bleeding Problems:	☐ No	☐ Yes	☐ ?
ALLERGIC/IMMUNOLOGIC			
Sjögren's Syndrome:	☐ No	☐ Yes	☐ ?
Lupus:	☐ No	☐ Yes	☐ ?
Other (including Multiple Sclerosis):	☐ No	☐ Yes	☐ ?
PSYCHIATRIC			
Memory Loss/Confusion:	☐ No	☐ Yes	☐ ?
Panic Attacks:	☐ No	☐ Yes	☐ ?
Insomnia:	☐ No	☐ Yes	☐ ?

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

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