

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

Vision Complaint: _____

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 any allergies to medications? Yes No If yes, explain: _____

Do you have or have you ever had?

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lazy eye	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cross eye	How long? _____	How long? _____
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> High Cholesterol	A1C: _____
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Eye Infection	How long? _____	<input type="checkbox"/> Cancer
<input type="checkbox"/> Other condition not listed: _____		<input type="checkbox"/> Retinal Hole/Detach	Type: _____
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Eye Surgery	Date: ___/___/___	Type: _____
			Date: ___/___/___

Are you pregnant? No Yes
Do you wear glasses? No Yes
Do you wear contacts? No Yes
Lens Type: Rigid Soft
Previous Contact Lens RX: **Brand:** _____ **Size:** _____
Power, Right eye: _____ **Power, Left eye:** _____

Are you nursing? No Yes
How old? _____ **Comfortable to wear?** No Yes
How old? _____ **Comfortable to wear?** No Yes
 Extended Wear Other: _____

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:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration:	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____	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: _____

