Medical History Questionnaire **Today's Date:____/____/____**

Patient / Medical History

Name:_____ **Date of Birth:**_____ **Social Security #:**_____-_____-_____

Mobile #:( )_____ **Home #:** ( )_____**Work #:**( )_____ **Preference:** Mobile / Home/ Work

Occupation:_____ **Last Eye Exam:**_____ **Email:**_____

How did you hear about us? □ Yellow Pages □ Online (Ex. Google, Bing, etc) □ Friend/Family □ Other_____

Reason for today's visit? _____

Do you have any allergies to medications? □ No □ Yes **If yes, explain:**_____

Do you have any environmental allergies? □ No □ Yes **If yes, explain:**_____

Are you currently taking any medications? □ No □ Yes **If yes, explain:**_____

_____

_____

Have you ever had any EYE injury or surgery? □ No □ Yes **If yes, explain:**_____

Do you use the computer? □ No □ Yes **If so, how many hours per day:**_____

Are you pregnant and/or nursing? □ No □ Yes **Do you wear contacts?** □ No □ Yes **If so, what brand?**_____

Review of Systems □ NONE

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

Constitutional: □ Fever □ Weight loss □ Weight gain □ Head Trauma	**Vascular/Cardiovascular:** □ Stroke □High Blood Pressure
Ears, Nose, Mouth, Throat:□Sinus Congestion □ Post-Nasal Drip □Dry mouth	**Respiratory:** □ Asthma □ Chronic bronchitis □ Emphysema
Gastrointestinal: □ Chron's □ Colitis □ Ulcer	**Genitourinary:** □ Kidneys □ Bladder
Bones/Joints/Muscles: □ Rheumatoid Arthritis □ Muscle Pain □ Joint Pain	**Integumentary:** □ Eczema □ Rosacea □ Psoriasis
Neurological: □ Headaches □ Seizures □ Multiple Sclerosis □ Epilepsy	**Psychiatric:** □ Bipolar □ Depression
Endocrine: □ Thyroid □ Diabetes	**Lymphatic / Hematologic:** □ Anemia □ Bleeding Problems
Allergic / Immunologic: □ Aids □ Infectious disease	**Eyes:** □ Double Vision □ Floaters □ Flashes □ Dryness

Ocular History □ None

□ Age-related macular degeneration
□ Amblyopia (lazy eye)
□ Cataract
□ Glaucoma
□ History of laser surgery
□ Ocular Hypertension (high pressures)
□ Retinal detachment
□ Retinal tear / hole
□ Tear film insufficiency (dry eyes)
□ Vitreous flashes
□ Vitreous floaters

Personal Medical History □ None

□ Anxiety
□ Arthritis
□ Asthma
□ Carotid Artery Occlusion
□ Congestive Heart Failure
□ Dementia
□ Diabetes Mellitus Type 1
□ Diabetes Mellitus Type 2
□ High Cholesterol
□ High Blood Pressure
□ Cancer, What kind? _____

Family History □ None

**** If yes, please indicate WHO****

□ Macular degeneration_____
□ Amblyopia (lazy eye)_____
□ Blindness_____
□ Cataract_____
□ Glaucoma_____
□ Arthritis_____
□ Cancer_____
□ Diabetes Mellitus_____
□ Thyroid disorder_____
□ High Cholesterol_____
□ High blood pressure_____
□ Family history unknown

Social History:

Do you use caffeine? □ No □ Yes **IF YES,** □ Light □ Moderate □ Heavy

Do you use illegal drugs? □ No □ Yes

Do you drink alcohol? □ No □ Yes **IF YES,** □ Former □ Light □ Moderate □ Heavy

Do you use tobacco products? □ No □ Yes **IF YES,** □ Current every day smoker □ Former smoker □ Light tobacco smoker