# MEDICAL HISTORY QUESTIONAIRE

**DATE:**_____

Patient Name | Address | City

State | Zip | Phone (Home) | Phone (Work) | Phone (Cell) | DOB

Primary Care Physician and Clinic Name

Address of Primary Care Physician | City | State | Zip | Phone

## HEALTH HISTORY

What is the main reason for today's exam?_____

Date of your last exam_____ (DD/MM/YY) Date of your last health exam_____ (DD/MM/YY)

Past Illnesses or Injuries:_____

Past Surgeries: _____

Current Medications: _____

_____

Current Eye Drops: _____

_____

Medicines that cause reactions or sensitivities:_____

Specific Allergies: _____

## EYE HISTORY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Macular Degeneration | ☐YES | ☐NO | Excess Tearing/Watering | ☐YES | ☐NO | Strabismus (Crossed Eyes) | ☐YES | ☐NO |
| Glaucoma | ☐YES | ☐NO | Dryness | ☐YES | ☐NO | Blurred Vision Distance | ☐YES | ☐NO |
| Cataract | ☐YES | ☐NO | Eye Pain or Soreness | ☐YES | ☐NO | Blurred Vision Near | ☐YES | ☐NO |
| Retinal Detachment | ☐YES | ☐NO | Foreign Body Sensation | ☐YES | ☐NO | Distorted Vision (halos) | ☐YES | ☐NO |
| Color Blindness | ☐YES | ☐NO | Infection of Eye or Lid | ☐YES | ☐NO | Double Vision | ☐YES | ☐NO |
| Headaches | ☐YES | ☐NO | Itching | ☐YES | ☐NO | Floaters or Spots | ☐YES | ☐NO |
| Glare/Light Sensitivity | ☐YES | ☐NO | Mucous Discharge | ☐YES | ☐NO | Fluctuating Vision | ☐YES | ☐NO |
| Tired Eyes | ☐YES | ☐NO | Drooping Eyelid | ☐YES | ☐NO | Loss of Vision | ☐YES | ☐NO |
| Amblyopia | ☐YES | ☐NO | Redness | ☐YES | ☐NO | Loss of Side Vision | ☐YES | ☐NO |
| Burning | ☐YES | ☐NO | Sandy or Gritty Feeling | ☐YES | ☐NO | | | |

## GENERAL HEALTH CONDITION

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fever | ☐YES | ☐NO | Respiratory (Asthma) | ☐YES | ☐NO | Anxiety or Depression | ☐YES | ☐NO |
| Weight Loss | ☐YES | ☐NO | Gastrointestinal | ☐YES | ☐NO | Thyroid, Diabetes | ☐YES | ☐NO |
| Other Symptoms | ☐YES | ☐NO | Kidney | ☐YES | ☐NO | Blood/Lymph | ☐YES | ☐NO |
| Ears, Nose, Throat | ☐YES | ☐NO | Muscles, Bones, Joints | ☐YES | ☐NO | Allergic | ☐YES | ☐NO |
| Cardiovascular (High BP, etc) | ☐YES | ☐NO | Skin | ☐YES | ☐NO | Are You? | ☐PREGNANT | |
| | | | Neurological (Multiple Sclerosis | ☐YES | ☐NO | | ☐NURSING | |

## FAMILY HISTORY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Amblyopia (Lazy Eye) | ☐YES | ☐NO | Retinal Detachment | ☐YES | ☐NO | High Blood Pressure | ☐YES | ☐NO |
| Blindness | ☐YES | ☐NO | Strabismus (Eye Turn) | ☐YES | ☐NO | Kidney Disease | ☐YES | ☐NO |
| Cataract(s) | ☐YES | ☐NO | Arthritis | ☐YES | ☐NO | Lupus | ☐YES | ☐NO |
| Color Blindness | ☐YES | ☐NO | Cancer | ☐YES | ☐NO | Stroke | ☐YES | ☐NO |
| Glaucoma | ☐YES | ☐NO | Diabetes | ☐YES | ☐NO | Thyroid Disease | ☐YES | ☐NO |
| Macular Degeneration | ☐YES | ☐NO | Heart Disease | ☐YES | ☐NO | Others | ☐YES | ☐NO |

**EYES IN THE 'BURG, OD**
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# MEDICAL HISTORY QUESTIONAIRE (continued)

## SPECTACLE LENS HISTORY

Do you use a computer? ☐YES ☐NO How many hours/day?_____ Distance from Computer?_____

Do you drive? ☐YES ☐NO Mileage to work each way?_____

Do you have glare problems? ☐YES ☐NO

Do you have visual difficulty when driving? ☐YES ☐NO

Do you have problems with night vision? ☐YES ☐NO

Do you currently wear glasses? ☐YES ☐NO SINCE_____

Type of glasses ☐FULL TIME ☐PART TIME ☐DISTANCE ☐CLOSE

Glasses Owned ☐SINGLE VISION ☐BIFOCALS ☐TRIFOCALS ☐BACKUP ☐SAFETY ☐SPORTS ☐PROGRESSIVE

Have you had trouble in the past with glasses? ☐YES ☐NO _____

Do you wear sunglasses ☐YES ☐NO Are your sunglasses your current prescription? ☐YES ☐NO

## SPECIAL EYEWEAR NEEDS

☐Computer (special perscriptions, special anti-glare tints or coatings ☐Safety Glasses (gardening, woodworking, welding)

☐Occupational (mechanics, plumbers, pilots) ☐Sports/Hobbies (racquet sports, shooting, motorcycle)

## CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐YES ☐NO

Have you ever tried to wear contact lenses? ☐YES ☐NO Reason for stopping? _____

Do you currently wear contact lenses? ☐YES ☐NO Since? (Year)_____

Type and brand of contact lenses _____ Today's wearing time (hours)? _____

How many hours/day? _____ How many days/week? _____

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Lens Comfort | _____ RIGHT | _____ LEFT | Distance Vision | _____ RIGHT | _____ LEFT | Near Vision | _____ RIGHT | _____ LEFT |

What Solutions do you use? _____ CLEANER _____ DISNIFECTANT _____ ENZYME

## SOCIAL HISTORY

Current Occupation: _____ Years _____ Employer _____

Do you use nutritional supplements (vitamins, etc)? ☐YES ☐NO

Do you engage in regular exercise? ☐YES ☐NO

Do you drink alcohol? ☐YES ☐NO If YES, how much/often ☐Occasional ☐1 Per Day ☐2-3 Day ☐4+/Day

Do you smoke? ☐YES ☐NO If YES, how much/often ☐Occasional ☐1/2 pack/Day ☐1 pack/Day ☐1+ Pack

Method of Tobacco Intake ☐SMOKING ☐CHEWING

Do you use illegal drugs? ☐YES ☐NO

Hobbies/Interests: _____

Please Read and Sign:

The patient portion is due at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

As a courtesy, Eyes In The' Burg will bill my insurance company. Payment from my insurance is to be paid directly to Eyes In The 'Burg. I understand that the above primary insurance will be billed on my behalf. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature_____Date: _____