Medical History Questionnaire

Name: _____
(Last) (First) (Middle)

Date of Birth:_____ Social Security Number:_____

What is the main reason for your visit (i.e. second opinion, LASIK consultation, etc.)?

_____

Referring Dr.:_____ City:_____Last seen on:_____

Family Dr.:_____ City:_____Last seen on:_____

Eye Dr.:_____ City:_____Last seen on:_____

SOCIAL HISTORY:

1. Occupation:_____ Retired?_____Other:_____
2. Marital Status: □Married □ Single □Widowed □Divorced □ Separated
3. Do you have children? □ Yes □ No If yes, how many? _____
4. Do you have any dietary restrictions? _____
5. Have you ever used tobacco? □ Yes □ No If yes, what form? _____
   In what amount?_____How many years? _____
6. What are your hobbies? _____

MEDICAL HISTORY:

7. Do you have any known drug or latex allergies? □ Yes □ No If yes, please list them:
   _____
8. Have you ever had a reaction to I.V. dye? □ Yes □ No If yes, please describe:
9. **Female Patients:**
   Are you pregnant or nursing? □ Yes □ No
10. Have you ever been hospitalized or had surgery? □ Yes □ No If yes, please list all previous surgeries and hospitalizations (include dates and hospitals where possible).
    _____
    _____
    _____
11. Do you take any eye medications? □ Yes □ No If yes, please list:

Medication	**Dosage**	**How Often?**

12. What other prescription medications do you take?

Medication	Dosage	How Often?

13. Do you take any antihistamines either prescription or over the counter? □ Yes □ No

14. List any other medicines, vitamins, or herbal supplements that you take:

Medication	Dosage	How Often?

15. Do you have asthma? □ Yes □ No
Do you have any breathing difficulties (i.e. shortness of breath, emphysema, etc.)?
□ Yes □ No If yes, please describe: _____

16. Has your medical doctor ever treated you for: (If yes, please describe and indicate how long.)

Sinus problems:	□ Yes	□ No
Diabetes:	□ Yes	□ No
If yes, do you take insulin?	□ Yes	□ No
High blood pressure:	□ Yes	□ No
Chest pain, irregular heart beat:	□ Yes	□ No
Heart attack:	□ Yes	□ No
Migraine:	□ Yes	□ No
Thyroid Disease:	□ Yes	□ No

Stroke:	□ Yes	□ No
Weakness on one side:	□ Yes	□ No
Seizure:	□ Yes	□ No
Loss of consciousness:	□ Yes	□ No
Arthritis:	□ Yes	□ No
Acid reflux or ulcers:	□ Yes	□ No
Kidney stones or gall stones:	□ Yes	□ No
Rashes:	□ Yes	□ No
Skin cancer:	□ Yes	□ No
Other types of cancer:	□ Yes	□ No
Seasonal Allergies:	□ Yes	□ No

OCULAR HISTORY:

17. Do you wear glasses? □ Yes □ No If so, how long? _____
18. Do you wear contact lenses? □ Yes □ No If so, how long? _____
19. Type of contact lenses? □ Soft □ Soft Toric □ Rigid Gas Permeable □ Scleral □ Hard
20. Date when you last wore your contact lenses_____
21. When was your last dilated eye exam? _____
22. When was your glasses/contacts prescription last changed? _____
23. Have you ever been diagnosed with Glaucoma or Keratoconus? □ Yes □ No
24. Have you ever had any eye surgery? □ Yes □ No
    If yes, please describe, including date and location: _____
25. Have you ever had any eye injury/trauma? □ Yes □ No
    If yes, please describe and give dates: _____
26. Have you ever had any laser surgery on your eyes? □ Yes □ No
    If yes, please indicate which eye and date of laser: _____
27. Have you ever been treated by an eye doctor for anything not listed above? □ Yes □ No If yes, please describe treatment: _____

FAMILY HISTORY:

28. Does anyone in your family (blood relative) have any of the medical conditions listed below? If you answer yes, please describe the relationship of the family member:

High blood pressure:	□ Yes	□ No
Diabetes:	□ Yes	□ No
Heart Disease:	□ Yes	□ No
Sickle cell disease:	□ Yes	□ No
Other diseases:	o Yes	o No

29. Does anyone in your family (blood relative) have any of the eye problems listed below? If you answer yes to any of the medical conditions listed below, please describe the problem and the relationship of the family member:

Blindness:	□ Yes	□ No
Glaucoma:	□ Yes	□ No
Retinal Detachment:	□ Yes	□ No
Keratoconus:	□ Yes	□ No
Lazy Eye:	□ Yes	□ No
Cross eyes:	□ Yes	□ No
Color blindness:	□ Yes	□ No
Night blindness:	□ Yes	□ No
Double vision:	□ Yes	□ No
Other eye diseases:	□ Yes	□ No

Reviewed by:_____ Date:_____
Physician