Medical History Questionnaire

Name: _____ Today's Date: _____

Guardian (If Applicable): _____ Occupation: _____

Birthdate: _____ Preferred Language: _____

Gender: _____ Race/Ethnicity: _____

Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

Name of Medical Doctor: _____ Dr's Phone: _____

Medical History

Do you have any allergies to medications? ☐ no ☐ yes 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:

_____

_____

_____

Check any of the following that you have had: ☐ crossed eyes ☐ lazy eye ☐ drooping eyelid ☐ prominent eyes
☐ Glaucoma ☐ retinal disease ☐ cataracts ☐ eye infections ☐ eye injury

Are you pregnant or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other: _____ Are they comfortable? ☐ yes ☐ no

Family History: note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship To You	Disease/Condition	No	Yes	?	Relationship To You
Blindness	☐	☐	☐		Cancer	☐	☐	☐	
Cataract	☐	☐	☐		Diabetes	☐	☐	☐	
Crossed Eyes	☐	☐	☐		Heart Disease	☐	☐	☐	
Glaucoma	☐	☐	☐		High Blood Pressure	☐	☐	☐	
Macular Degeneration	☐	☐	☐		Kidney Disease	☐	☐	☐	
Retinal Detachment or Disease	☐	☐	☐		Lupus	☐	☐	☐	
Arthritis	☐	☐	☐		Thyroid Disease	☐	☐	☐	
Other:	☐	☐	☐		Other:	☐	☐	☐	

COVID-19 Vaccination Status: ☐ Unvaccinated ☐ Vaccinated - please check Product Name and list Date Received below:

Dose 1: ☐ Pfizer ☐ Moderna ☐ J&J | Date: _____ Dose 2: ☐ Pfizer ☐ Moderna ☐ J&J | Date: _____

Booster 1: ☐ Pfizer ☐ Moderna ☐ J&J | Date: _____ Booster 2: ☐ Pfizer ☐ Moderna ☐ J&J | Date: _____

Other 1: ☐ Pfizer ☐ Moderna ☐ J&J | Date: _____ Other 2: ☐ Pfizer ☐ Moderna ☐ J&J | Date: _____

Please Turn This Form Over & Complete Side Two

Social History: *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

Do you use tobacco products? ☐ no ☐ yes If yes, state amount/how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, state amount/how long: _____

Do you use cannabis? ☐ no ☐ yes If yes, state amount/how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, state amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems: Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary (Skin)	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection, Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

System	NO	YES	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular / Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic / Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic / Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

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

Doctor's Signature

Date