Medical History Questionnaire ☐ Established Patient ☐ New Patient Today's Date:_____

Name:_____Date of Birth:_____ ☐ Male ☐ Female

Referring/Specialty Dr._____City:_____

Primary Care Physician:_____ City:_____

Pharmacy:_____Street & City:_____

Last Eye Exam: Date:_____Location:_____

Section 1: Current Vision Needs OTHER RX

I need: ☐ Routine Eye Exam ☐ New Glasses ☐ Contact Lenses ☐ I have other vision problems listed below.

I am: ☐ Farsighted ☐ Nearsighted ☐ Unknown

Do you currently wear glasses? ☐ No ☐ Yes Type: ☐ Readers ☐ Bifocals ☐ Trifocals ☐ Progressive Lenses

Do you wear contact lenses? ☐ No ☐ Yes Type:_____

Section 2: Current Eye Conditions (Please check all that apply) HPI

☐ No Ocular or Vision Related Complaints - Skip to Section 3

☐ Blurred Vision, Distance	☐ Red Eyes	☐ Double Vision
☐ Blurred Vision, Near	☐ Itching	☐ Decreased Vision
☐ Floaters	☐ Tearing	☐ Distortion of Vision
☐ Flashes	☐ Pain	☐ Glare
☐ Curtain or Veil Over Vision	☐ Discharge	☐ Headache
☐ Dry Eyes	☐ Light Sensitivity	

Section 3: Past Ocular History and Current Medical Status: (Please check all that apply) XHPI

☐ No History of Eye Problems - Skip to Section 4

☐ Ambyopia (Lazy Eye)	☐ Retinal Detachment	☐ Cataracts
☐ Diabetic Retinopathy	☐ Dry Eyes	☐ Glaucoma
☐ Keratoconus	☐ Macular Degeneration	☐ Optic Neuritis

☐ Other:_____

Are you pregnant or nursing? ☐ No ☐ Yes

If diabetic, 1) Last Blood Sugar_____Date_____

2) Last A1C_____Date_____

Section 4: Current Eye Medications, Including Eye Drops: (Please list dosage/frequency) SPECIALTY MEDS

☐ No Current Eye Medications - Skip to Section 5

_____	_____	_____
_____	_____	_____
_____	_____	_____

Name_____

Section 5: Other Medical History: (Please check all that apply) PMHX

☐ No History of Illness - Skip to Section 6

☐ Alzheimer's
☐ Arthritis
☐ Asthma
☐ Cancer Type_____
☐ Congestive Heart Failure
☐ COPD
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Hearing Loss/Hard of Hearing
☐ Headache
☐ Heart Attack/Disease
☐ Hepatitis A / B / C
☐ Herpes Simplex
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Lupus
☐ Meningitis
☐ Migraines
☐ MRSA
☐ Psychiatric Disorder
☐ Stroke
☐ Syphilis
☐ Thyroid Disease

☐ Other:_____

Section 6: Ocular Surgeries: (Please check all that apply) SURGICAL HX

☐ No Prior Ocular Surgery - Skip to Section 7

R	L		R	L		R	L	
☐	☐	Foreign Body Removal	☐	☐	Punctal Plugs	☐	☐	RK
☐	☐	Blepharoplasty	☐	☐	Retinal Surgery	☐	☐	Strabismus Surgery
☐	☐	LASIK	☐	☐	PRK	☐	☐	Other_____
☐	☐	Corneal Transplant	☐	☐	Cataract Surgery			

Section 7: All Other Medications: (Please list dosage and frequency, including supplements) SYS MEDS

☐ No other medications - Skip to Section 8

_____ _____ _____

_____ _____ _____

_____ _____ _____

Section 8: Allergies to Medication ALLERGIES

☐ No Known Medication Allergies - Skip to Section 9

Medication	Reaction	Severity
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Name_____

Section 9: Family History: (Please check family association) FAMILY HX

	Mother	Father	Sister	Brother	Aunt	Uncle	Grandmother	Grandfather
☐ Macular Degeneration	_____	_____	_____	_____	____	____	_____	_____
☐ Cataracts	_____	_____	_____	_____	____	____	_____	_____
☐ Glaucoma	_____	_____	_____	_____	____	____	_____	_____
☐ Retinal Detachment	_____	_____	_____	_____	____	____	_____	_____
☐ Amplyopia (Lazy Eye)	_____	_____	_____	_____	____	____	_____	_____
☐ Diabetes	_____	_____	_____	_____	____	____	_____	_____
☐ Heart Disease	_____	_____	_____	_____	____	____	_____	_____
☐ High Blood Pressure/Hypertension	_____	_____	_____	_____	____	____	_____	_____
☐ Kidney Disease	_____	_____	_____	_____	____	____	_____	_____
☐ Stroke	_____	_____	_____	_____	____	____	_____	_____

☐ Other_____

Section 10: Social History: (Please check all that apply) SOCIAL HX

Smoking: ☐ Never Smoked ☐ Former Smoker ☐ Current some day smoker ☐ Current every day smoker
☐ Vaping ☐ Chewing Tobacco

Alcohol Use: ☐ No ☐ Yes If yes, how much and how often?_____

Recreational Drug Use: ☐ No ☐ Yes If yes, what drugs, and how often?_____

_____

Patient or Guardian/Caregiver Signature: (Please sign and date below)

Signature: _____Date:_____