ACUITY eye center

MEDICAL HISTORY QUESTIONNAIRE

Today's Date:_____

Last Name: _____ First Name: _____ Nickname: _____

Address: _____ Home Phone:_____

City/State: _____ Zip: _____ Work Phone:_____

Birth Date: _____ Social Security #: _____ Gender: M F Cell Phone:_____

Race: _____ Ethnicity: _____ Primary Language: _____

Parent/Guardian(if applicable) _____ Relationship: _____

Occupation: _____ Employer: _____

Last Eye Exam: _____ Last Medical Exam: _____

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

If this is your first visit, how did you hear about us? ☐ Insurance ☐Internet ☐Flyer ☐Friend_____

MEDICAL HISTORY

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and herbal supplements):_____

_____

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

_____

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 or ☐ Eye injury, explain:_____
Are you pregnant and/or nursing? ☐ Yes ☐ No If yes, how many weeks pregnant or nursing_____
Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?_____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other Are they comfortable? ☐ Yes ☐ No
Do you sleep in your contact lenses? ☐ Yes ☐ No What brand of contacts do you wear ? _____
If you are not currently a contact lens wearer, are you interested in contact lenses? ☐ Yes☐ No

FAMILY HISTORY

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

DISEASE/CONDITION		RELATIONSHIP TO YOU
Glaucoma	☐ No ☐ Yes	_____
Cataract	☐ No ☐ Yes	_____
Macular Degeneration	☐ No ☐ Yes	_____
Retinal Detachment/Disease	☐ No ☐ Yes	_____
Blindness	☐ No ☐ Yes	_____
Turned/Lazy Eye	☐ No ☐ Yes	_____
Diabetes	☐ No ☐ Yes	_____
Cancer	☐ No ☐ Yes	_____
Heart Disease	☐ No ☐ Yes	_____
High Blood Pressure	☐ No ☐ Yes	_____
Arthritis	☐ No ☐ Yes	_____
Kidney Disease	☐ No ☐ Yes	_____
Lupus	☐ No ☐ Yes	_____
Thyroid Disease	☐ No ☐ Yes	_____
Other	☐ No ☐ Yes	_____

-OVER-

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion 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, type/amount/how long: _____
Do you drink alcohol? □ No □ Yes If yes, type/amount/how long: _____
Do you use illegal drugs? □ No □ Yes If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ Tuberculosis □ N/A

HEALTH HISTORY/REVIEW OF SYSTEMS

Do you currently, or have you ever been prone to any problems in the following areas:

CONSTITUTIONAL
- Fever □ No □ Yes
- Weight Loss/Gain □ No □ Yes

CARDIOVASCULAR/VASCULAR
- Heart Trouble/Pain □ No □ Yes
- High Blood Pressure □ No □ Yes
- Vascular Disease □ No □ Yes

EARS, NOSE, MOUTH, THROAT
- Allergies/Hay Fever □ No □ Yes
- Chronic Cough □ No □ Yes
- Dry Throat/Mouth □ No □ Yes
- Ear Infection □ No □ Yes
- Sinus Congestion □ No □ Yes

RESPIRATORY
- Asthma □ No □ Yes
- Chronic Bronchitis □ No □ Yes
- Emphysema □ No □ Yes

GASTROINTESTINAL
- Constipation □ No □ Yes
- Diarrhea □ No □ Yes

GENITOURINARY
- Bladder □ No □ Yes
- Kidney □ No □ Yes

MUSCULOSKELETAL
- Arthritis/Rheumatoid □ No □ Yes
- Joint Pain □ No □ Yes
- Muscle Pain □ No □ Yes

INTEGUMENTARY (Skin) □ No □ Yes

NEUROLOGICAL
- Headaches □ No □ Yes
- Migraines □ No □ Yes
- Seizures □ No □ Yes

PSYCHIATRIC □ No □ Yes

ENDOCRINE
- Diabetes □ No □ Yes
- Thyroid/Other Glands □ No □ Yes

HEMATOLOGIC/LYMPHATIC
- Anemia □ No □ Yes
- Bleeding Problems □ No □ Yes
- Hepatitis □ No □ Yes

IMMUNOLOGIC
- AIDS/HIV □ No □ Yes
- Syphilis □ No □ Yes

EYES
- Blurred Vision □ No □ Yes
- Burning □ No □ Yes
- Distorted Vision/Halos □ No □ Yes
- Double Vision □ No □ Yes
- Dryness □ No □ Yes
- Excess Tearing/Watering □ No □ Yes
- Eye Pain or Soreness □ No □ Yes
- Flashes/Floaters in Vision □ No □ Yes
- Foreign Body Sensation □ No □ Yes
- Glare/Light Sensitivity □ No □ Yes
- Glaucoma □ No □ Yes
- Infection of Eye or Lid □ No □ Yes
- Itching □ No □ Yes
- Loss of Side Vision □ No □ Yes
- Loss of Vision □ No □ Yes
- Mucous Discharge □ No □ Yes
- Retinal Tear/Detachment □ No □ Yes
- Redness □ No □ Yes
- Sandy or Gritty Feeling □ No □ Yes
- Styes or Chalazion □ No □ Yes
- Tired Eyes □ No □ Yes

If you answered YES to any of the above or have a condition not listed, please explain _____
_____
_____
_____

Patient/Guardian Signature:_____Date:_____ Doctor:_____