Medical History Questionnaire

Reviewed w/patient__________ MD/OD initials
Date______________

Name____ Birth Date____________________________
Name of physician referring you____
Do you wear glasses (circle) YES or NO If YES, how long have you had the current pair:____________
Do you wear contacts (circle) YES or NO If YES, how long have you had the current pair:____________

Are you interested in receiving information on: ☐ Laser Vision Correction ☐ Medical/Cosmetic BOTOX®
☐ Juvederm® ☐ Gentle Waves® Non-Invasive Wrinkle Reduction ☐ Laser Skin Tightening and Toning

List any medications, including eye drops, that you take:____
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

List any Vitamins, nutritional Supplements, or herbs that you take:_____________________________________
______________________________ ______________________________ ______________________________

Do you have (circle) DIABETES / HEART DISEASE / HIGH BLOOD PRESSURE
List all major illness and injuries (dates):____
______________________________ ______________________________ ______________________________
List surgeries you have had:______________________________ ______________________________
______________________________ ______________________________ ______________________________

Allergies to any medications or foods: Sulfa drugs / Fluorescein Dye / Iodine / Penicillin
If others, please list:____

REVIEW OF SYSTEMS
Do you currently have any problems in the following areas? If "yes," provide additional information.

Constitutional Symptoms:	**NO**	**YES**	**Explanation of problem:**
Fever	_____	_____	____________________________________
Weight loss	_____	_____	____________________________________
Fatigue	_____	_____	____________________________________
Eyes			
Loss of vision	_____	_____	____________________________________
Blurred vision (halos)	_____	_____	____________________________________
Loss of side vision	_____	_____	____________________________________
Double vision	_____	_____	____________________________________
Dryness	_____	_____	____________________________________
Mucous discharge	_____	_____	____________________________________
Redness	_____	_____	____________________________________
Sandy or gritty feeling	_____	_____	____________________________________
Itching	_____	_____	____________________________________
Burning	_____	_____	____________________________________
Foreign body sensation	_____	_____	____________________________________
Excess tearing watering	_____	_____	____________________________________
Occasional tearing	_____	_____	____________________________________
Glare/Light sensitivity	_____	_____	____________________________________
Eye pain or soreness	_____	_____	____________________________________
Chronic infection of eye or lid	_____	_____	____________________________________
Stye or chalazion	_____	_____	____________________________________
Fluctuating visual acuity	_____	_____	____________________________________
Ears, nose, mouth, throat:			
Sinus congestion	_____	_____	____________________________________
Runny nose / Post nasal drip	_____	_____	____________________________________
Chronic cough	_____	_____	____________________________________
Dry or sore throat/mouth	_____	_____	____________________________________
Respiratory:			
Shortness of breath / cough	_____	_____	____________________________________

[PLEASE COMPLETE OTHER SIDE]

	NO	YES	Explanation of problem:
Cardiovascular:			
heart failure / heart attack (MI)	_____	_____	_____
irregular heart beat (arrhythmia)	_____	_____	_____
Gastrointestinal: (stomach / intestines)			
Ulcers/heartburn/diarrhea/vomiting	_____	_____	_____
Urinary:			
Pain or discomfort/blood in urine	_____	_____	_____
Musculoskeletal:			
Muscle/joint pain	_____	_____	_____
Skin:			
Rashes/dryness/moles/cancer	_____	_____	_____
Neurologic:			
Numbness, weakness	_____	_____	_____
Migraine headaches	_____	_____	_____
Stroke (CVA) or paralysis	_____	_____	_____
Endocrine:			
Heat or cold intolerance/Diabetes	_____	_____	_____
Hematologic/Lymphatic:			
Bleeding/bruising	_____	_____	_____
swollen lymph nodes	_____	_____	_____
Allergic/immunologic:			
HIV or AIDS	_____	_____	_____
Allergy symptoms	_____	_____	_____
sneezing/itching rashes	_____	_____	_____
Psychiatric:			
Depression/anxiety	_____	_____	_____
FAMILY HISTORY			
Blindness	_____	_____	_____
Cataract	_____	_____	_____
Glaucoma	_____	_____	_____
Macular degeneration	_____	_____	_____
Retinal detachment	_____	_____	_____
Arthritis	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart disease	_____	_____	_____
High blood pressure	_____	_____	_____
Kidney disease	_____	_____	_____
Lupus	_____	_____	_____
Sjogren's disease	_____	_____	_____
Stroke	_____	_____	_____
Thyroid disease	_____	_____	_____
Tuberculosis	_____	_____	_____

Other:____

Social History: Current occupation:________________________ or Retired from:________________________

	NO	YES	Explanation:
Do you drive?	_____	_____	_____
Difficulty with driving?	_____	_____	_____
Do you have problems with night vision?	_____	_____	_____
Do you drink alcohol?	_____	_____	number of drinks per week:_____
Do you smoke?	_____	_____	number of packs per day:_____
Have you ever had a blood transfusion?	_____	_____	_____
Are you pregnant/nursing?	_____	_____	delivery date: _____

Have you ever been treated or exposed to an infectious disease: Hepatitis A B C / HIV / AIDS / Syphilis