

## Form Usage Instructions

**To use this form you must have Acrobat Reader 5 or greater installed.**

[Click here](#) to download the current version of Adobe Acrobat Reader.

- Use the tab key to move from form field to form field.
- To enter in text, tab to (or click in) the area you wish to type in and begin typing.
- To check off choices on the form (yes/no type), click in the boxed or underlined area and an “x” or check mark should appear.
- To print out a copy of the form to retain for your records, click on the “Print Form” button toward the bottom of the last page.

**If you experience difficulty submitting this form, please follow these directions:**

1. Print the form.
2. Complete with black pen and bring the form to the office at the time of your appointment.
3. If you do not have a printer, you can fill out the form at the office prior to your appointment.

Please fill out the form as completely as possible. If you have any questions, please contact your doctor.

Our Focus is on you...

Board Certified Renowned Specialists.

The Care & Quality You Deserve.

**MEDICAL HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth/age \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

List any **medications** you currently take (prescription and over the counter):

\_\_\_\_\_

Which **skin products** do you use for eye/face? \_\_\_\_\_

Do you have **allergies** to any medications?  YES  NO

If yes list the medications: \_\_\_\_\_

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

\_\_\_\_\_

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.):

\_\_\_\_\_

Do you **currently** have any problems in the following areas? If "YES", please provide explanation

	YES	NO	Explanation of Problem
<b>EYES</b> (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Loss of side vision			
Double vision			
Dryness			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Mucous discharge			
Excess tearing/watering			
Glare/light sensation			
Eye pain or soreness			
Infection of eye lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
<b>GENERAL/CONSTITUTIONAL</b>			
Fever			
Weight loss			
Fatigue/Other			
Pregnant			

	YES	NO	EXPLANATION OF PROBLEM
<b>EARS, NOSE, THROAT</b> (Sinus, ear infection, chronic cough, dry mouth, hearing loss, etc)			
<b>CARDIOVASCULAR</b> (Heart, vessels, etc.)			
<b>RESPIRATORY</b> (Asthma, emphysema, etc.)			
<b>GASTROINTESTINAL</b> (Stomach ulcers, intestinal diseases, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b>			
<b>MUSCLES, BONES, JOINT</b> (Arthritis, etc.)			
<b>SKIN</b> (Acne, warts, skin cancer, etc.)			
<b>NEUROLOGICAL</b> (Multiple sclerosis, etc.)			
<b>PSYCHIATRIC</b> (Anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (Diabetes, hypothyroid, etc.)			
<b>BLOOD/LYMPH</b> (cholesterolemia, anemia, etc.)			
<b>ALLERGIC/ IMMUNOLOGIC</b> (Hay fever, lupus, Sjogrens, etc.)			

### FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	EXPLANATION OF PROBLEM
Blindness			
Glaucoma			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

### SOCIAL HISTORY

Do you drive?  YES  NO  
Do you have visual difficulty when driving?  YES  NO  
Do you have problems with night vision?  YES  NO  
Have you ever tried to use contact lenses?  YES  NO  
Do you currently wear contact lenses?  YES  NO  
If YES, how long have you worn lenses? \_\_\_\_\_  
Do you currently wear glasses?  YES  NO  
If YES, how long have you worn the current prescription? \_\_\_\_\_  
Do you drink alcohol?  YES  NO If YES: occasional 1 per day 2-3 /day 4+ /day  
Do you smoke?  YES  NO If YES: occasional 1/2 pack /day 1 pack /day 1+ pack  
Have you ever had a blood transfusion?  YES  NO  
History reviewed.  No Changes.  Additions as noted above.

Patient Signature \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_

#### Are you interested in any of the following (check)?

Contact lenses    Laser vision correction    Laser skin rejuvenation    Non-surgical wrinkle reduction