

Confidential Medical History Questionnaire

Name: _____ Preferred Name: _____ Date of Birth: _____
 Referring Doctor: _____ Spouse Name: _____
 Family Doctor: _____ Home Phone: _____ Cell Phone: _____
 Will this visit be billed to Workman's compensation? **Yes / No** Occupation: _____

CURRENT COMPLAINT / SYMPTOMS EVEN WITH GLASSES ON (please check)

Blur at distance	Blur at near	Blur at intermediate (computer / TV)	
Glare / Halos at night	Poor color vision	Double Vision	Different vision between eyes
Film / Haze	Eye Strain	Loss of Depth Perception	Headaches / Migraines
Floaters	Flashes	Dry Eyes	Pain / Injury
Burn / Sting	Itching / Scratchy	Allergy	Discharge / Watering
Swelling	Redness	Foreign Body	Missing / Waves in vision
Bump on / near eye			

Are the symptoms in your **Right / Left / Both?** How bothersome are the symptoms? **Severe / Moderate / Mild**
 How long have you had the symptoms? _____ Are the symptoms always there? **Yes / No**
 Are these symptoms affecting your lifestyle? **Yes / No** Hobbies _____

Have you had any injuries due to your poor vision? **Yes / No**

Explain _____

Do you feel as though you might sustain an injury due to your poor vision? **Yes / No**

Do you feel your vision is bothersome enough to consider a surgical procedure at this time? **Yes / No**

Would you like a new glasses prescription at this visit? **Yes / No** Do you understand our refraction policy? **Yes / No**

If you had to wear glasses, would you rather have a correction for... **Distance / Near / Both ?**

Do you currently drive? **Yes / No** Have you ever used: Plaquenil Flomax Fosamax

Do you... Smoke / Drink / Use street drugs?

Do you currently have problems with... (please check)

Skin	Neck / Back	Stomach	Lymph System	Thyroid
Head	Lungs / Breathing	Genitals / Kidney	Blood	Immune Disorders
Ears / Nose / Throat	Heart	Bones / Muscles	Stroke / Seizure	Psychiatric
Pregnant / Nursing	Liver	AIDS / HIV	Herpes / Cold Sores	Gonorrhea
Hepatitis _____	Tuberculosis	Chlamydia	Syphilis	Cancer

High Blood Pressure / How Long? _____

Diabetic / Blood Sugar Level _____

Current Medications:

Drug Allergies: None

Hospitalizations / Illnesses: _____

OVER PLEASE →

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Eye Information

Have you ever had any of these (please check)?

Cataracts	Glaucoma	Retinal Detachment / Tear	Keratoconus
Eye Turn / Strabismus	Double Vision	Lazy Eye / Amblyopia	Trauma
Foreign Body	Herpes Simplex / Zoster	Macular Degeneration	
Other _____			

Surgery:

R / L Cataracts	Glaucoma	Retinal Surgery	Muscle Surgery
Corneal Transplant	Eyelid Surgery	Removal of Growth	RK / AK
PRK	LASIK		
Other _____			

Relatives (only those in blood relation to you)

Your Family Ocular History and their relationship to you:

Cataracts _____	Glaucoma _____	Ptosis _____
Retinal Detachment / Tear _____	Keratoconus _____	Blindness _____
Eye Turn / Strabismus _____	Lazy Eye / Amblyopia _____	
Macular Degeneration _____	Other _____	

Your Family Medical History and their relationship to you:

Diabetes _____	High Blood Pressure _____	Cancer _____
Arthritis _____	Kidney Disease _____	Stroke _____
Thyroid _____	Heart Attack _____	Alzheimer's _____
Other _____		

Who may we thank for referring you to our clinic?

Name: _____ Relationship: _____
Address: _____

- I HAVE LOOKED BOTH PAGES OF THIS FORM OVER AND ALL OF THE INFORMATION CONTAINED ON IT IS CORRECT TO THE BEST OF MY KNOWLEDGE.
- PLEASE SIGN AND DATE EACH VISIT ONCE YOU HAVE REVIEWED YOUR INFORMATION.

Signature: _____	Date: _____	Signature: _____	Date: _____
Signature: _____	Date: _____	Signature: _____	Date: _____
Signature: _____	Date: _____	Signature: _____	Date: _____
Signature: _____	Date: _____	Signature: _____	Date: _____