



**MEDICAL HISTORY QUESTIONNAIRE**  
(Return to Technician when done)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear about us?  Family  Friend  Internet  JOX  Talk 99.5  Next Round  
 Other: \_\_\_\_\_  Doctor: \_\_\_\_\_

**Reason for Today's Visit/Lifestyle Needs Assessment/Personal Goals:**

\_\_\_\_\_

**Do you have any of the following issues with your eyes?**

	Yes	No		Yes	No
Blurred Vision	<input type="radio"/>	<input type="radio"/>	Burning	<input type="radio"/>	<input type="radio"/>
Double Vision	<input type="radio"/>	<input type="radio"/>	Dryness	<input type="radio"/>	<input type="radio"/>
Foreign Body Feeling	<input type="radio"/>	<input type="radio"/>	Tearing/Watering	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	Eye Fatigue	<input type="radio"/>	<input type="radio"/>
Discharge	<input type="radio"/>	<input type="radio"/>	Scratchiness/Grittiness	<input type="radio"/>	<input type="radio"/>
Soreness/Irritation	<input type="radio"/>	<input type="radio"/>			

OTHER: \_\_\_\_\_

**Does your vision make any of the following activities difficult?**

	Yes	No		Yes	No		Yes	No
Driving at night	<input type="radio"/>	<input type="radio"/>	Reading small print	<input type="radio"/>	<input type="radio"/>	Watching TV	<input type="radio"/>	<input type="radio"/>
Driving during day	<input type="radio"/>	<input type="radio"/>	Reading street signs	<input type="radio"/>	<input type="radio"/>			
Halos around lights	<input type="radio"/>	<input type="radio"/>	Glare	<input type="radio"/>	<input type="radio"/>			

OTHER: \_\_\_\_\_

**Do you have/have you ever had any of the following?**

	Yes	No		Yes	No		Yes	No
Cataract	<input type="radio"/>	<input type="radio"/>	Floaters	<input type="radio"/>	<input type="radio"/>	Dry Eye	<input type="radio"/>	<input type="radio"/>
Diabetic Retinopathy	<input type="radio"/>	<input type="radio"/>	Eye Injury	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	Contact lens	<input type="radio"/>	<input type="radio"/>	Floaters		
"Lazy"/Crossed Eye	<input type="radio"/>	<input type="radio"/>	Glasses	<input type="radio"/>	<input type="radio"/>			

OTHER: \_\_\_\_\_

Please list all prior surgeries (including eye surgeries) and date of surgery:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



PRIMARY CARE PHYSICIAN: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

Patient consent to pull medication history **Yes**  **No**

PLEASE CIRCLE Y or N and provide Month/Year

Have you received the flu vaccine in the last 12 months? **Y N** Date: \_\_\_\_\_

Have you received the pneumonia vaccine? **Y N** Date: \_\_\_\_\_

Have you received the shingles vaccine? **Y N** Date: \_\_\_\_\_

Are you currently pregnant? **Y N** Currently nursing? **Y N** On Hormone Replacement Therapy? **Y N**

Please list your current medications including eye drops or check none  None

\_\_\_\_\_  
 \_\_\_\_\_

Have you had or do you currently have:

	Yes	No		Yes	No		Yes	No
Asthma / COPD	<input type="radio"/>	<input type="radio"/>	Irregular heart beat	<input type="radio"/>	<input type="radio"/>	Thyroid	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Shingles	<input type="radio"/>	<input type="radio"/>	Dialysis	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Rheumatoid	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Sarcoidosis	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>
Other: _____								

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  local anesthetics  Latex  Sulfa drugs

Other Allergies: \_\_\_\_\_

Do you have any of the following symptoms?

	Yes	No		Yes	No		Yes	No
Hearing problems	<input type="radio"/>	<input type="radio"/>	Trouble urinating	<input type="radio"/>	<input type="radio"/>	Breathing	<input type="radio"/>	<input type="radio"/>
Cough or wheeze	<input type="radio"/>	<input type="radio"/>	Rashes	<input type="radio"/>	<input type="radio"/>	Legs swelling	<input type="radio"/>	<input type="radio"/>
Dry throat/mouth	<input type="radio"/>	<input type="radio"/>	Poor balance	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>
Sinus congestion	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>	Abdomen pain	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Weight loss	<input type="radio"/>	<input type="radio"/>	Appetite change	<input type="radio"/>	<input type="radio"/>

Family & Social History

Please list any eye or medical problems in your parents, grandparents or siblings?

Check any of the following that you currently use?  Alcohol  Tobacco  Drugs

Date \_\_\_\_\_

Patient Signature \_\_\_\_\_