Patient ID#

Patient Name:_____ Date:_____

Birth date:_____ Gender: *Male* *Female* Marital Status: *Single* *Married* *Other*

Address:_____City_____State/Zip_____

Phone: Home_____Work_____Cell_____ Email_____

Social Security#:_____ Employment Status: *Employed* *Retired* *Full-time* *Student* *None*

Medical Doctor:_____Dr's Phone:_____Date of last eye exam _____By whom:_____

Employer:_____Occupation:_____

Responsible Party Name if other than patient: _____DOB:_____

Name of **Vision Insurance** Company:_____

Subscriber Name: _____Birth date:_____

Subscriber ID#_____Group#_____

Relationship to Patient:_____Employer:_____

Name of **Medical Insurance** Company:_____

Subscriber Name: _____Birth date:_____

Subscriber ID#_____Group#_____

Relationship to Patient:_____Employer:_____

Chief Complaint:_____

FOR OFFICE USE ONLY:

History of Present Illness:

Symptoms:	Location:	Quality:
Severity:	Duration:	Timing:
Context:	Modifiers:	

Medical History & ROS from _____reviewed ☐ no changes Dr. initials:_____

V.A. sc Rx	Dist	Near
OD	20/	20/
OS	20/	20/
OU	20/	20/

V.A. cc Rx (habitual)	Dist	Near
OD	20/	20/
OS	20/	20/
OU	20/	20/

Habitual Rx	Sph	Cyl	Axis	Prism	Add
OD					
OS					

Seg Ht. Type

P.D. Total Distance Near

K's

OD

OS

CVF ☐nl	**Adnexa/Eyelids:** ☐nl	**Pupils:** Size: OD___ OS___
Motility: ☐ Full	☐ Blepharitis OD OS OU	☐ no afferent defect NPC___
Cover Test: ☐ Eso___ ☐Exo___☐Ortho	☐ Meibomianitis OD OS OU	☐ round OU ACC___

Ret: OD 20/

OS 20/

Monc: OD 20/ PH 20/

OS 20/ 20/

BVA: OD 20/ ADD

OS 20/

Cyclo: OD 20/

OS 20/

Final: OD 20/ ADD OR

OS 20/

Contact Trial Lens Fit:

OD 1.

OR

2.

OR

OS 1.

OR

2.

Order:

Brand BC

OD:

OS:

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Birth Date: _____/_____/_____

MEDICAL HISTORY

List medications you are taking (including oral contraceptives, aspirin, over the counter medications and home remedies including vitamins)

_____

_____

Are you allergic to any medications? _____

List all major injuries or surgeries and/ or hospitalizations you have had:

_____

_____

Have you had any of the following:

❒crossed eyes ❒lazy eyes ❒drooping eyelid ❒prominent eyes ❒glaucoma

❒retinal disease ❒cataracts ❒eye infections ❒eye injury

Do you wear glasses? ❒yes ❒no How old are your current lenses?_____

Do you wear contact lenses? ❒yes ❒no How old are your current contacts?_____

Type of contacts: _____ Are they comfortable? ❒yes ❒no

Are you pregnant and/ or nursing: ❒yes ❒no

FAMILY HISTORY

Have any of your parents, grandparents, siblings, children; living or deceased had any of the following?

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Crossed eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Thyroid Disease	❒	❒	❒	_____
Retinal Detachment	❒	❒	❒	_____
Retinal Disease	❒	❒	❒	_____
Arthritis	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
High Blood Pressure	❒	❒	❒	_____
Kidney Disease	❒	❒	❒	_____
Lupus	❒	❒	❒	_____

Other:_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive: ❒yes ❒no Do you have visual difficulty when driving? ❒yes ❒no

Do you use tobacco products? ❒yes ❒no Type/amount/how long_____

Do you drink alcohol? ❒yes ❒no Type/amount/how long_____

Do you use illegal drugs? ❒yes ❒no Type/amount/how long_____

Have you ever been exposed to or infected with :

❒Gonorrhea ❒Hepatitis ❒HIV ❒Syphilis

REVIEW OF SYSTEMS:

Do you currently, or have you ever had any problems in the following areas?

	YES	NO	?
CONSTITUTIONAL:			
Prolonged fever	❒	❒	❒
Sudden weight gain/loss	❒	❒	❒
Skin problems	❒	❒	❒
NEUROLOGICAL:			
Headaches	❒	❒	❒
Migranes	❒	❒	❒
Seizures	❒	❒	❒
EYES:			
Loss of vision	❒	❒	❒
Blurred vision	❒	❒	❒
Distorted vision/halos	❒	❒	❒
Loss of side vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain/Soreness	❒	❒	❒
Infection of Eye/Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE:			
Thyroid/Other Glands	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒

	YES	NO	?
EAR, NOSE, MOUTH, THROAT			
Allergies/hay fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
VASCULAR/ CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENTIOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC/HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIES	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

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

_____

_____

_____

_____ _____

Doctor's Signature Date