236 N. Market Street Inglewood, CA 90301 (310) 671-2020 • (310) 671-2784 (fax)

Medical History Questionnaire

Name : _____ Today's Date : _____ / _____ / _____

Birth Date : _____ / _____ / _____ Social Security # : _____ / _____ / _____ Last Eye Exam : _____ / _____ / _____

Name of Medical Doctor : _____ Dr's. Phone : (_____) _____ - _____

Last Medical Exam: _____ / _____ / _____

Medical History

Do you have any allergies to medications? **NO** **YES** *If Yes, explain* _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications):

_____

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

_____

List any of the following that you have had: *crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury?*

List any eye disease that you are being treated for _____

Are you pregnant and/or nursing? ❑**NO** ❑**YES** _____

Do you wear glasses? ❑**NO** ❑**YES** *If yes how old our your present pair of glasses ?* _____

Do you wear lenses? ❑**NO** ❑**YES** *If yes how old our your present pair of lenses ?* _____

Type of contact lenses: ❑**Rigid** ❑**Soft** ❑**Extended Wear** ❑**Other**

Are they comfortable? **NO** **YES** _____

Family History

Please note any family history (parents, grandparents, siblings children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	❑NO	❑YES	*If Yes* _____
Cataract	❑NO	❑YES	*If Yes* _____
Crossed Eyes	❑NO	❑YES	*If Yes* _____
Glaucoma	❑NO	❑YES	*If Yes* _____
Macular Degeneration	❑NO	❑YES	*If Yes* _____
Retinal Detachment/Disease	❑NO	❑YES	*If Yes* _____
Arthritis	❑NO	❑YES	*If Yes* _____
Cancer	❑NO	❑YES	*If Yes* _____
Diabetes	❑NO	❑YES	*If Yes* _____
Heart Disease	❑NO	❑YES	*If Yes* _____
High Blood Pressure	❑NO	❑YES	*If Yes* _____
Kidney Disease	❑NO	❑YES	*If Yes* _____
Lupus	❑ NO	❑ YES	*If Yes* _____
Thyroid Disease	❑NO	❑YES	*If Yes* _____
Other	❑NO	❑YES	*If Yes* _____

Social History

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

❑ Yes, I would prefer to discuss.

DISEASE/CONDITION	NO	YES		
Do you drive?	❑ NO	❑ YES	*If Yes*	_____
If you drive, do you have visual difficulty when driving?	❑ NO	❑ YES	*If Yes*	_____
Do you use tobacco products?	❑ NO	❑ YES	*If Yes*	_____
Do you drink alcohol?	❑ NO	❑ YES	*If Yes*	_____

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain & list medications)

SYSTEM	NO	YES		EXPLAIN / LIST MEDICATIONS
Constitulional *(fever, weight loss/gain)*	❑ NO	❑ YES	*If Yes*	_____
Inegumentary *(skin)*	❑ NO	❑ YES	*If Yes*	_____

Neurological

Headaches	❑ NO	❑ YES		_____
Migraines	❑ NO	❑ YES	*If Yes*	_____
Seizures	❑ NO	❑ YES	*If Yes*	_____

Eyes

Loss of Vision	❑ NO	❑ YES	*If Yes*	_____
Blurred Vision	❑ NO	❑ YES	*If Yes*	_____
Distorted Vision/Halos	❑ NO	❑ YES	*If Yes*	_____
Double Vision El	❑ NO	❑ YES	*If Yes*	_____
Dryness	❑ NO	❑ YES	*If Yes*	_____
Mucous Discharge	❑ NO	❑ YES	*If Yes*	_____
Redness	❑ NO	❑ YES	*If Yes*	_____
Sandy or Gritty Feeling	❑ NO	❑ YES	*If Yes*	_____
Itching	❑ NO	❑ YES	*If Yes*	_____
Burning	❑ NO	❑ YES	*If Yes*	_____
Excess Tearing/Watering	❑ NO	❑ YES	*If Yes*	_____
Glare/Light Sensitivity	❑ NO	❑ YES	*If Yes*	_____
Eye Pain or Soreness	❑ NO	❑ YES	*If Yes*	_____
Chronic Infection of Eye or Lid	❑ NO	❑ YES	*If Yes*	_____
Sties or Chalazion	❑ NO	❑ YES	*If Yes*	_____
Flashes/Floaters in Vision	❑ NO	❑ YES	*If Yes*	_____

EARS, NOSE, MOUTH, THROAT

Allergies/Hay Fever	❑ NO	❑ YES	*If Yes*	_____
Sinus Congestion	❑ NO	❑ YES	*If Yes*	_____
Runny Nose	❑ NO	❑ YES	*If Yes*	_____
Chronic Cough	❑ NO	❑ YES	*If Yes*	_____
Dry Throat/Mouth	❑ NO	❑ YES	*If Yes*	_____

RESPIRATORY

Asthma	❑ NO ❑ YES	*If Yes*	_____
Chronic Bronchitis	❑ NO ❑ YES	*If Yes*	_____
Emphysema	❑ NO ❑ YES	*If Yes*	_____

VASCULAR / CARDIOVASCULAR

Diabetes	❑ NO ❑ YES	*If Yes*	_____
Heart Pain	❑ NO ❑ YES	*If Yes*	_____
High Blood Pressure	❑ NO ❑ YES	*If Yes*	_____
Vascular Disease	❑ NO ❑ YES		_____

GASTROINTESTINAL

Liver Disease	❑ NO ❑ YES	*If Yes*	_____

GENITOURINARY

(genitals/kidney/bladder)	❑ NO ❑ YES	*If Yes*	_____

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	❑ NO ❑ YES	*If Yes*	_____

LYMPHATIC / HEMATOLOGIC

Anemia	❑ NO ❑ YES	*If Yes*	_____
Bleeding Problems	❑ NO ❑ YES	*If Yes*	_____

ENDOCRINE

(thyroid/other glands)	❑ NO ❑ YES	*If Yes*	_____
ALLERGIC/IMMUNOLOGIC	❑ NO ❑ YES	*If Yes*	_____
PSYCHIATRIC	❑ NO ❑ YES	*If Yes*	_____

_____ _____

Doctor's Signature Date