FORM 3

MEDICAL HISTORY QUESTIONAIRE

Patient Name: Today's Date:

Medical Doctor: ______________ City / State: ______________

Last Eye Exam: ________ Previous Eye Doctor: ______________ City / State: ______________
Month Year

Do you wear glasses? If Yes, age of your current Rx? Type of glasses?

Do you wear contacts? If Yes, age of your current lenses? Type of contacts?

What brand of contact lenses do you wear? Right Eye: ______________ Left Eye: ______________

How often do you replace your contacts?

PERSONAL MEDICAL HISTORY: *(Review of Systems)*

Have you ever been diagnosed with any of the following MEDICAL conditions? *(Please check all that apply and enter other condition if applicable.)*

CARDIOVASCULAR
- Elevated Cholesterol
- Heart Disease
- Hypertension
- Stroke (CVA)
- Other:

EAR, NOSE, MOUTH, THROAT
- Other:

ENDOCRINE
- Diabetes Mellitus
- Thyroid Disease
- Other:

GASTROINTESTINAL
- Cancer: Colon / Liver
- Inflammatory Bowel (IBS)
- Other:

GENITOURINARY
- Cancer: Prostate / Kidney
- Cancer: Ovarian / Uterine
- Other:

HEMATOLOGIC/LYMPHATIC
- Cancer: Breast
- Leukemia / Lymphoma
- Other:

IMMUNOLOGIC
- Histoplasmosis
- Sjogren's Syndrome
- Other:

INTEGUMENTARY (SKIN)
- Basal/Squamous Cell Carcinoma
- Rosecea: Acne / Ocular
- Other:

MUSCULOSKELETAL
- Arthritis: Osteo/Rheumatoid
- Down's Syndrome
- Other:

NEUROLOGIC
- Bell's Palsy
- Headaches/Migraines
- Multiple Sclerosis
- Myasthenia Gravis
- Other:

PSYCHIATRIC
- Other:

RESPIRATORY
- Asthma/Bronchitis/COPD
- Cancer: Lung
- Other:

PERSONAL OCULAR HISTORY:

Have you ever been diagnosed with any of the following OCULAR conditions? *(Please check all that apply and enter other condition if applicable.)*

- Amblyopia (Crossed / Lazy Eye)
- Blindness
- Choroidal Nevus (Freckle)
- Cataracts
- Diabetic Retinopathy
- Dry Eye Syndrome
- Glaucoma
- Macular Degeneration
- Ocular Allergies
- Retinal Detachment/Disease
- Vitreal Floaters
- Other:

Have you ever had any surgeries on your EYES? Yes No If Yes, please indicate what type and approximate Month/Year.

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FAMILY OCULAR HISTORY:

Has anyone in your immediate family ever been diagnosed with any of the following OCULAR conditions? Please check all that apply and select that person with the closest relation to you. [e.g. mother, father, brother, sister, grandfather, grandmother, uncle or aunt.]

Amblyopia (Lazy Eye):	Diabetic Retinopathy:	Retinal Detach/Disease:
Blindness:	Glaucoma:	Strabismus (Crossed Eye):
Cataracts:	Macular Degeneration:	Other Ocular Disease:

FAMILY MEDICAL HISTORY:

Has anyone in your immediate family ever been diagnosed with any of the following MEDICAL conditions? Please check all that apply and select that person with the closest relation to you. [e.g. mother, father, brother, sister, grandfather, grandmother, uncle or aunt.]

Cancer:	Heart Disease:	Hypertension:
CVA (Stroke):	High Cholesterol:	Thyroid Disease:
Diabetes Mellitus:		

MEDICATIONS:

Are you taking any PRESCRIPTION or OTC medications? Yes No If YES, please list (or provide a copy of) those meds.

Are you allergic to any medications? Yes No If YES, please list those medications.

SOCIAL HISTORY:

TOBACCO USE - Please select that option which most closely represents your personal use of tobacco.

Never Smoked		
Current Smokeless Tobacco User		
Former Smoker	Stopped Smoking:	
Current Everyday Smoker	Packs per Day:	Years Smoking:
Current Someday Smoker	Packs per Day:	Years Smoking:

ALCOHOL USE - Please select that option which most closely represents your personal use of alcohol.

None Social Use Only 1-2 Drinks Daily Above Average Use Alcohol Dependence

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How did you hear about our office?

Established Patient	Website / Online	Referral - Family Doctor	Referral - Family or Friend
Yellow Pages/Phone Book	Insurance Company	Walk-in	Name of person we can thank: