Medical History Questionnaire

Name:		Fill out and check your preferred method of contact: ☐ Phone
Street Address:		☐ Email
City, State, ZIP:		☐ Text
Birth Date:	☐ male ☐ female	Soc Sec # (last 4 digits): XXX - XX -
Name of Last Eye Doctor: Date of Last Eye Exam:	Phone # (if known):	Occupation:
How did you hear about our office? ☐ VSP website ☐ other website ___________________ ☐ friend ___________________ ☐ other ___________________ ☐ phonebook		Today's Date:

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/ African American ☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White
Ethnicity ☐ Hispanic or Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Not Hispanic/Latino

Reason for today's visit: ____

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:

Check any of the following that you have had:
☐ crossed eyes ☐ lazy eye ☐ retinal disease ☐ cataracts ☐ eye surgery
☐ drooping eyelid ☐ glaucoma ☐ eye infections ☐ eye injury

Are you pregnant and/or nursing? ☐ No ☐ Yes
Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended ☐ Other Are they comfortable? ☐ No ☐ Yes

Family history Please note any family history (parents, grandparents, siblings, children; living or deceased):

DISEASE/CONDITION	RELATIONSHIP	DISEASE/CONDITION	RELATIONSHIP
☐ Blindness	___________________________	☐ Diabetes	___________________________
☐ Cataract	___________________________	☐ Heart Disease	___________________________
☐ Crossed Eyes	___________________________	☐ High Blood Pressure	___________________________
☐ Glaucoma	___________________________	☐ Kidney Disease	___________________________
☐ Macular Degeneration	___________________________	☐ Lupus	___________________________
☐ Retinal Detachment/Disease	___________________________	☐ Thyroid Disease	___________________________
☐ Arthritis	___________________________	☐ Other_____________	___________________________
☐ Cancer	___________________________		

Social History (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)
☐ I would prefer to discuss my Social History information directly with my doctor and not complete the remainder of this page.

Do you drive: ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, describe:

Do you use tobacco products? ☐ No ☐ Yes If yes, type amount/how long:
Do you drink alcohol? ☐ No ☐ Yes If yes, type amount/how long:
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ NONE

Review of Systems

Please check if you have or ever had any **unusual/persistent** problems in the following areas:

Constitutional
- ☐ Fever
- ☐ Weight Loss/Gain

Skin
- ☐ Rash

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

Ears, Nose, Mouth, Throat
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

☐ **Allergic/Immunologic**

Eyes
- ☐ Loss of Vision
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Itching
- ☐ Excess Tearing/Watering
- ☐ Glare/Light Sensitivity
- ☐ Eye Pain or Soreness
- ☐ Chronic Infection of Eye or Lid
- ☐ Flashes/Floaters in Vision

Genitourinary
- ☐ Genitals/Kidney/Bladder

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation

Psychiatric
- ☐ Anxiety/Stress
- ☐ Depression

Vascular/Cardiovascular
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Vascular Disease

Endocrine
- ☐ Diabetes
- ☐ Gout
- ☐ Hypoglycemia
- ☐ Thyroid disorder
- ☐ Cholesterol (elevated)
- ☐ Pituary

Bones/Joints/Muscles
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

Lymphatic/Hematologic
- ☐ Anemia
- ☐ Bleeding Problems

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

☐ **I do not have any of the above listed conditions**

Information Change (Fill this section on all visits after the first, initial visit)
Please **date**, **write changes** (or write “NO CHANGE” if none), and **initial**

Date	**Changes**	**Initial**

For Office Use Only

Reviewed:______________________________ Date:_______________