OPTIQUE FAMILY VISION CARE

MEDICAL HISTORY QUESTIONNAIRE

PATIENT CODE _____ DATE_____

MEDICATIONS YOU ARE TAKING - CURRENTLY_____
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ____ NO ____
IF YES, LIST MEDICATION(S)_____

LIST ANY MAJOR ILLNESSES YOU HAVE. (Glaucoma, Macular Degeneration, Diabetes, Heart Disease, High Blood Pressure, Lupus, etc.) _____
_____

LIST ANY SURGERIES YOU HAVE HAD. (Cataracts removed, Appendix, etc.) _____
_____

LIST ANY INJURIES / TRAUMA. (Concussions, Vehicle or other accidents) _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

EYES (Blurred vision, pain, watering, dryness, itching, burning) YES ____ NO ____
_____

EYES (Macular Degeneration, Cataracts, Glaucoma, Lazy/Crossed Eyes YES ____ NO ____
_____

GENERAL / CONSTITUTIONAL (Fever, Stroke, Weight Loss/Gain, YES ____ NO ____
Unusually tired) _____

EAR, NOSE, THROAT (Hard of hearing, Stuffy nose, Earache, YES ____ NO ____
Cough, Dry Mouth, etc.)_____

CARDIOVASCULAR (Heart disease, High blood pressure, etc.) YES ____ NO ____
_____

RESPIRATORY (Congested, Wheezing/Shortness of breath, etc.) YES ____ NO ____
_____

GASTROINTESTINAL (Diarrhea, Constipation, Hernia, Ulcers, YES ____ NO ____
Upset stomach, other) _____

GENITAL, KIDNEY, BLADDER (Painful / frequent urination, YES ____ NO ____
Frequent infections) _____

FEMALES (Pregnant or nursing) YES ____ NO ____

MUSCLES, BONES, JOINTS (Joint pain, Swelling, Stiffness, YES ____ NO ____
Arthritis, Cramps, other) _____

SKIN (Acne, Rash, Growths, Redness, Bruise easily, other) YES ____ NO ____
_____

PATIENT CODE _____

NEUROLOGICAL (Numbness, Headaches, Seizures, Paralysis, other) YES ____ NO ____
_____

PSYCHIATRIC (Anxiety, Depression, Insomnia, other) _____ YES ____ NO ____

ENDOCRINE (Diabetes, Thyroid, etc.) _____ YES ____ NO ____

BLOOD / LYMPH (Bleeding, Cholesterol, Anemia, other) _____ YES ____ NO ____

ALLERGIC / IMMUNOLOGIC (Swelling, Itching, Redness, Hives, YES ____ NO ____
Lupus, Aids, other) _____

FAMILY HISTORY

HAS ANY MEMBER OF YOUR FAMILY HAD THESE DISEASES? YES ____ NO ____
Blindness, Cataracts, Glaucoma, Macular Degeneration, Diabetes,
High Blood Pressure, Heart Disease, Stroke, Cancer, Thyroid disease, other...
IF YES, WHICH FAMILY MEMBER? _____

SOCIAL HISTORY

DOES YOUR VISION LIMIT YOUR DAILY ACTIVITY? _____ YES ____ NO ____
(Reading, Driving, Sports, Crafts, Work, other)

DO YOU: SMOKE? YES ____ NO ____ IF YES, HOW MUCH & HOW LONG? _____

DRINK ALCOHOL? YES ____ NO ____ IF YES, HOW MUCH? _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES ____ NO ____

DATE OF LAST EYE EXAM: _____

WHO PERFORMED YOUR LAST EYE EXAM? _____

WHAT TYPE OF EXAM ARE YOU INTERESTED IN TODAY - GLASSES OR CONTACT LENSES?
(Please circle.)
HAVE YOU WORN CONTACT LENSES BEFORE? YES ____ NO ____
If yes, what type? _____

NAME OF MEDICAL DOCTOR: _____

DATE OF LAST MEDICAL EXAM: _____

CHIEF COMPLAINT(S) TODAY: _____
_____
_____