Eye Physicians of the East Bay

MEDICAL HISTORY QUESTIONNAIRE

Last name, First name: ______________________ Birthdate: __________ Today's Date: __________

Last Eye Exam: __________ Physician: ______________________ Last Medical Exam: __________

Do you wear: Glasses? □ Age of current pair? __________ Contacts? □ Age of current pair? __________

Tell us about any unusual visual needs you may have for your work or hobbies: ______________________
Are you interested in finding out more about Contact Lenses or Laser Vision Correction? ______________________

Past Ocular History/Conditions/Surgeries:

Condition	Date of Onset	Treatment

List any Medications including Ocular Medications You Currently Use *(also include oral contraceptives, aspirin, over the counter medications and home remedies):*

Drug	Strength/Dose/Directions	Purpose (ie. for high blood pressure)

Do you have any allergies to medications? □ No □ Yes If yes, explain: ______________________
Are you pregnant and or nursing? □ No □ Yes ______________________

Past Medical History/Conditions/Surgeries:

Condition	Date of Onset	Treatment

****Please turn over to complete other side of this form****

Family History for the following conditions *(Note any family history: parents, grandparents, siblings, children, living or deceased)***:**

Disease / Condition	**No**	**Yes**	**?**	**Relationship to You**
Blindness	______	______	______	____________________
Cataract	______	______	______	____________________
Crossed Eyes	______	______	______	____________________
Glaucoma	______	______	______	____________________
Macular Degeneration	______	______	______	____________________
Retinal Detachment/Disease	______	______	______	____________________
Arthritis	______	______	______	____________________
Cancer	______	______	______	____________________
Diabetes	______	______	______	____________________
Heart Disease	______	______	______	____________________
High Blood Pressure	______	______	______	____________________
Kidney Disease	______	______	______	____________________
Lupus	______	______	______	____________________
Thyroid Disease	______	______	______	____________________
Other ____________________	______	______	______	____________________

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 my Social History information directly with my doctor. (Check box)

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: ____

Do you use illegal drugs? □ No □ Yes If yes, type/amount/how long:____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Where were you born and raised? ____

Review of Systems: Do you currently have any problems in the following areas? (Such as)?

SYSTEM	**No**	**Yes**	**If yes, please list symptoms**
CONSTITUTIONAL (Fever,Weight Loss/Gain)			
INTEGUMENTARY (Skin rash)	□	□	
NEUROLOGICAL: (headaches/seizures)	□	□	
EYES (blurred, distorted, double vision, dryness, mucous discharge, redness, itching, burness, tearing, foreign body sensation, glare, styes, flashes, floaters)	□	□	
ENDOCRINE (thyroid, diabetes, fatigue)			
PSYCHIATRIC (depression, schizophrenia)	□	□	
EARS, NOSE, MOUTH, THROAT (hay fever, sinus, post nasal drip, runny nose)	□	□	
RESPIRATORY (cough, shortness of breath)	□	□	
CARDIOVASCULAR (heart pain, leg claudication)	□	□	
GASTROINTESTINAL (diarrhea, constipation, pain)	□	□	
GENITOURINARY	□	□	
(incontinence, dialysis, bladder infection)	□	□	
MUSCULOSKELETAL (joint/muscle pain)	□	□	
HEMATOLOGIC/LYMPHATIC (anemia, bleeding problems)	□	□	
ALLERGIC/IMMUNOLOGIC (lupus, active allergy)	□	□	