Eye Care Associates
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Medical History Questionaire

Name: Today's Date:
Address: Birth Date:
Social Security #:
Phone: Email: Last Eye Exam:
Name of Medical Doctor: How did you learn about our office?
Medical Doctor's Address:
Insurance Company:
Dr.'s Phone: Last Medical Exam:

Eye Care Issues

Do you have more than 1 pair of glasses? ☐ no ☐ yes
Do you work on the computer? ☐ no ☐ yes
Do you spend a lot of time outdoors? ☐ no ☐ yes
If you wear bifocals, are you bothered by the lines? ☐ no ☐ yes
Are there times you'd rather not wear glasses? ☐ no ☐ yes
If you wear contacts, are you satisfied with vision and comfort? ☐ no ☐ yes
Are you interested in trying the newest contacts available? ☐ no ☐ yes
Please list any complaints about wearing glasses or contacts:

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.*

Do you drive? ☐ no ☐ yes
If yes, do you have any difficulty when driving? ☐ no ☐ yes
If yes, please 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 a sexually transmitted disease? ☐ no ☐ yes
If yes what type? ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphillis

Medical History

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

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

Do you have any allergies to medications? ☐ no ☐ yes
If yes, explain:

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 ☐ Other
Are they comfortable? ☐ no ☐ yes

Family History

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

	No	Yes	Relationship		No	Yes	Relationship
Blindness	☐	☐		Diabetes	☐	☐	
Cataract	☐	☐		Macular Degeneration	☐	☐	
Crossed Eyes	☐	☐		Retinal Detachment	☐	☐	
Glaucoma	☐	☐		Arthritis	☐	☐	
Heart Disease	☐	☐		Kidney Disease	☐	☐	
Cancer	☐	☐		Thyroid Disease	☐	☐	
Lupus	☐	☐		Other	☐	☐	

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

System	No	Yes	?
CONSTITUTIONAL			
Fever, Weight Gain / Loss	☐	☐	☐
INTEGUMENTARY (SKIN)	☐	☐	☐
Skin Cancer	☐	☐	☐
If yes, what type?			
NEUROLOGICAL			
Headaches or Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred or Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching or Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes of Light	☐	☐	☐
Floaters in Vision	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐
ALLERGIC / IMMUNOLOGICAL	☐	☐	☐

System	No	Yes	?
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
COPD	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Heart Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
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 & list medications:

Doctor's Signature: Date: