Plaza Lane Optometry

Medical History Questionnaire

Name:____Date:_________/_________/____________

Birth Date: _____/______/_______Last Medical Exam _____/______/______ Last Eye Exam: _____/______/_______

Name of Medical Doctor: ____Dr's Phone: _______________________

Personal Medical History

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain:_______________________________________

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

____

____

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

____

Circle any of the following that you have had and describe: **crossed eyes** ● **lazy eye** ● **drooping eyelid** ● **prominent eye** ● **glaucoma**, **retinal disease** ● **cataracts** ● **eye infections** ● **eye injury**?____

____

Do you experience symptoms of nausea while reading in a moving car? ☐ Yes ☐ No

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No ● Age of glasses__________

Do you currently wear contact lenses? ☐ Yes ☐ No ● Type? ☐Rigid ☐Soft ☐Wear Over-Night

If you do not wear contact lenses now but have worn them in the past, when did you last wear your lenses ______________________

Family History

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

	No	**Yes**	**Unknown**	**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

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

____

____

____

Please turn this form over and complete side two

Review of Systems

Do you currently have any problems in the following areas: (If YES, please explain and list medications)

System	NO	YES	?
Skin	☐	☐	☐
Neurologic			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes	☐	☐	☐
Floaters	☐	☐	☐
Tired Eyes	☐	☐	☐
Ears, Nose, Mouth, Throat			
Allergies	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐

System	NO	YES	?
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Endocrine (thyroid/other glands)	☐	☐	☐

Describe:____

Patient Signature____Date______________________________

Date	Status Change	Patient Initials