DANIA EYETECH Optical CENTER

DISEASES AND REFRACTIVE SURGERY • CONTACT LENSES AND EYEWEAR

Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

City/ST/Zip: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ Last Eye Exam: _____

Social Security #: _____ Dr. Phone: _____

Name of Medical Dr.: _____ Last Medical Exam: _____

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 & home remedies:

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

Have you ever had any of the following: (Please circle) crossed eyes lazy eye glaucoma cataracts
drooping eyelid prominent eye retinal disease eye infections eye injury

Are you pregnant or nursing? No Yes

Do you wear glasses? No Yes If yes, how old are your present pair of glasses? _____

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

Type of contact lenses: Rigid Soft Extended Wear Other Are the comfortable?
No Yes

FAMILY HISTORY

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

Disease/Condition	Please circle appropriate answer			Relationship to You
Blindness	No	Yes	?	
Cataracts	No	Yes	?	
Crossed Eyes	No	Yes	?	
Glaucoma	No	Yes	?	
Macular Degeneration	No	Yes	?	
Retinal Detachment/Disease	No	Yes	?	
Arthritis	No	Yes	?	
Cancer	No	Yes	?	
Diabetes	No	Yes	?	
Heart Disease	No	Yes	?	
Lupus	No	Yes	?	
Kidney Disease	No	Yes	?	
Thyroid Disease	No	Yes	?	
High Blood Pressure	No	Yes	?	
Other	No	Yes	?	

Please turn over and complete side two

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

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

Do you use tobacco products? No Yes If yes, type/amount/how long? _____

Do you drink alcohol? No Yes Ifyes, type/amount/how long? _____

Do you use illegal drugs? No Yes Ifyes, type/amount/how long? _____

Have you ever been exposed to or infected with: _____Gonorrhea ____Hepatitis _____HIV _____Syphilis

REVIEW OF SYSTEMS

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

SYSTEM	Please circle appropriate answer			SYSTEM	Please circle appropriate answer		
CONSTITUTIONAL				**EARS, NOSE, MOUTH, THROAT**			
Fever, weight loss/gain	NO	YES	?	Allergies/Hay Fever	NO	YES	?
INTEGUMENTARY (skin)	NO	YES	?	Sinus Congestion	NO	YES	?
NEUROLOGICAL				Runny Nose	NO	YES	?
Headaches	NO	YES	?	Post-Nasal Drip	NO	YES	?
Migraines	NO	YES	?	Chronic Cough	NO	YES	?
Seizures	NO	YES	?	Dry Throat/Mouth	NO	YES	?
EYES				**RESPIRATORY**			
Loss of Vision	NO	YES	?	Asthma	NO	YES	?
Blurred Vision	NO	YES	?	Chronic Bronchitis	NO	YES	?
Distorted Vision/Halos	NO	YES	?	Emphysema	NO	YES	?
				VASCULAR/			
Loss of Side Vision	NO	YES	?	**CARDIOVASCULAR**			
Double Vision	NO	YES	?	Diabetes	NO	YES	?
Dryness	NO	YES	?	Heart Pain	NO	YES	?
Redness	NO	YES	?	High Blood Pressure	NO	YES	?
Mucous Discharge	NO	YES	?	Vascular Disease	NO	YES	?
Sandy or Gritty Feeling	NO	YES	?	**GASTROINTESTINAL**			
Itching	NO	YES	?	Diarrhea	NO	YES	?
Burning	NO	YES	?	Constipation	NO	YES	?
Foreign Body Sensation	NO	YES	?	**GENITOURINARY**			
Excess Tearing/Watering	NO	YES	?	Genitals/Kidney/Bladder	NO	YES	?
Glare/Light Sensitivity	NO	YES	?	**BONES/JOINTS/MUSCLES**			
Eye Pain/Soreness	NO	YES	?	Rheumatoid Arthritis	NO	YES	?
Chronic Infection of Eye/Lid	NO	YES	?	Muscle Pain	NO	YES	?
Sties or Chalazion	NO	YES	?	Joint Pain	NO	YES	?
Flashes/Floaters in Vision	NO	YES	?	**LYMPHATIC/HEMATOLOGIC**			
Tired Eyes	NO	YES	?	Anemia	NO	YES	?
ENDOCRINE				Bleeding Problems	NO	YES	?
Thyroid/Other Glands	NO	YES	?	**ALLERGIC/IMUNOLOGIC**	NO	YES	?
				PHYCHIATRIC	NO	YES	?

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

Dr. Signature: _____ Date: _____