Medical History Form Date:

Name: _____ Date of Birth: _____
Last First Middle
Social Security #: _____
Home Address: _____ Work Number: ( ) _____
_____ Home Number: ( ) _____
_____ Email: _____

Previous Optometrist: _____ Last Eye Exam: _____
Occupation: _____ Employer: _____
Employer's Phone Number: _____ Employer's Address: _____
Special Interest (hobbies, sports): _____

In Case of Emergency, Contact

Name: _____ Relationship: _____
Home Number: _____ Work Number: _____

Medical History

Do you have any allergies to medication? ☐No ☐Yes If yes, please explain _____
_____
List any medications you are taking (including oral contraceptives, aspirin, over the counter medication and home remedies): ____
_____
_____
_____
List all major injures, surgeries and/or hospitalizations you have had: _____
_____
_____
List any of the following that you have had crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____
_____
_____
Are you pregnant or nursing? ☐No ☐Yes
Do you wear glasses? ☐No ☐Yes If yes, how old are your current glasses? _____
Do you wear contact lenses? ☐No ☐Yes If yes, how old is your current pair? _____
What type of contact lenses: ☐Disposable Soft Lenses ☐Standard Soft Lenses ☐Rigid
If you use disposable lenses, how often do you throw them away? _____
What solution do you use? _____ Do you ever sleep in your lenses? ☐No ☐Yes

Family History

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

	Yes	No	?	How are they related 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 _____	☐	☐	☐	_____

Please turn this form over and complete the other side →

Social History

Do you drive? ☐Yes ☐No If yes, do you have difficulty with vision while driving? ☐Yes ☐No
Do you use tobacco products? ☐Yes ☐No If yes, type/amount/how many years: _____
Do you drink alcohol? ☐Yes ☐No If yes, type/amount/how many years: _____
Do you use illegal drugs? ☐Yes ☐No If yes, type/amount/how many years: _____
Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐None

Review of System

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

	Yes	No	?
Constitutional			
Fever/Weight Changes	☐	☐	☐
Integumentary (skin)	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Seizures	☐	☐	☐
Eye			
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 Eye Infection	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

	Yes	No	?
Ears/Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/kidney/bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

How did you hear Eye Q Optometric Designs? ☐ Friend Referral_____ ☐ Insurance Provider
☐ Physician Referral _____ ☐ Walk-in

I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize my doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I acknowledge that I received and or read a copy of Eye Q Optometric Designs's Notice of Privacy Practices.

Signature_____ Today's Date_____
Patient Signature

Signature_____ Today's Date_____
Guardian's Signature if under 18

E-mail Form