portland eyecare Medical History Questionnaire

Date: Email Address:

Name: ◯ M ◯ F Phone:

Address: Work Phone:

City: Zip: Last Eye Exam: mm/yy

Social Security #: Name of Medical Doctor:

Birth Date: Medical Dr.'s Phone #:

Your Profession: Last Medical Exam: mm/yy

MEDICAL HISTORY

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:

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

Do you wear glasses (including readers)? ◯ yes ◯ no How frequently do you wear them?

Do you wear contact lenses? ◯ yes ◯ no How frequently do you wear them?

Are you pregnant and/or nursing? ◯ yes ◯ no

* Would you like a contact lens prescription with this exam? ◯ yes ◯ no

Have you worn them before? ◯ yes ◯ no

If you answered "yes", what is your current contact lens information?

Brand: Base Curve (BC): Powers:

** Please note, there are additional fees above and beyond the usual and customary fee for a routine eye examination to provide you with a lens prescription, even for current wearers. These fees are not applicable to most major insurances.*

Do you drive? ◯ yes ◯ no

If yes do you have visual difficulty when driving? ◯ yes ◯ no

If yes, please describe:

FAMILY HISTORY

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

DISEASE/CONDITION	YES	NO	?	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				

portland eyecare Medical History Questionnaire

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 use tobacco products? ◯ yes ◯ no If yes, type, amount, how long? _____

Do you drink alcohol? ◯ yes ◯ no If yes, type, amount, how long? _____

Do you use illegal drugs? ◯ yes ◯ no If yes, type, amount, how long? _____

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

REVIEW OF SYSTEMS

Have you had a recent cold/flu/respiratory infection? ◯ yes ◯ no Do you currently, or have you ever had any **chronic** problems in the following areas below? **Items marked with a * are of the most importance.**

SYSTEM	YES	NO	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	◯	◯	◯
INTEGUMENTARY			
Skin	◯	◯	◯
NEUROLOGICAL			
Headaches	◯	◯	◯
* Migraines	◯	◯	◯
Seizures	◯	◯	◯
EYES			
* Blurred Vision	◯	◯	◯
* Distorted Vision/Halos	◯	◯	◯
* Loss of Side Vision	◯	◯	◯
* Double Vision	◯	◯	◯
* Dryness	◯	◯	◯
* Infection of Eye or Lid	◯	◯	◯
* Redness	◯	◯	◯
* Sandy and Gritty Feeling	◯	◯	◯
* Itching	◯	◯	◯
* Burning	◯	◯	◯
* Foreign Body Sensation	◯	◯	◯
* Excess Tearing/Watering	◯	◯	◯
* Glare/Light Sensitivity	◯	◯	◯
* Eye Pain or Soreness	◯	◯	◯
* Sties or Chalazion	◯	◯	◯
* Floaters	◯	◯	◯
* Flashes	◯	◯	◯
* Tired Eyes	◯	◯	◯
ENDOCRINE			
Thyroid/Other Glands	◯	◯	◯
* Diabetes	◯	◯	◯

SYSTEM	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			
Heart Disease	◯	◯	◯
High Blood Pressure	◯	◯	◯
High Cholesterol	◯	◯	◯
GASTROINTESTINAL GENETOURINARY			
Genital/Kidney/Bladder	◯	◯	◯
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	◯	◯	◯
Muscle Pain	◯	◯	◯
Joint Pain	◯	◯	◯
LYMPHATIC/HEMATOLOGIC			
Anemia	◯	◯	◯
Bleeding Problems	◯	◯	◯
ALLERGIC/IMMUNOLOGIC			
Bleeding problems	◯	◯	◯
PSYCHIATRIC			

If you have a condition not listed, please explain:

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

Doctors Initials: **Date:**