Medical History Questionnaire

Today's Date:_____/_____/________

Patient: Full Name:________________________________ Nickname:____________ D.O.B.___/___/______
Full Address:____
Home Phone:(   )__________________ Cell:(   )_________________ Email:_________________________

Information below is for: ☐Patient (if adult) ☐Parent (if minor) ☐Responsible party and/or caretaker
Name:______________________________ (If different than patient) Address____ (If different than patient)
Work #:(   )________________X______ Home #:(   )________________ Cell #:(   )________________
Email:_____________________________ Social Security #:______/_____/______ D.Lic.#:_______________
Employer:____ Occupation:______________________________

Family members living at home: (include last name if different)

SPOUSE:________________________ DOB:_________ Child:__________________________ DOB:_________
Child:__________________________ DOB:_________ Child:__________________________ DOB:_________
Child:__________________________ DOB:_________ Child:__________________________ DOB:_________

Medical History (Patient)

Do you have allergies to medications? ☐ no ☐ yes 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: crossed eyes • lazy eye • drooping eyelid • prominent eyes • glaucoma

retinal disease • cataracts • eye infections • eye injury

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

Family History

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

DISEASE/CONDITION	NO	YES	?	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

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

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual 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: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently have any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
NEUROLOGICAL			
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	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐

	NO	YES	?
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	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

___

___

___

___

___

I understand that I am financially responsible for all charges whether or not paid by insurance, including reasonable costs of collection in the event of default. I hereby authorize San Clemente Optometry to release any information to secure the payment of benefits as well as the use of this signature on all insurance submittals.