Medical History Questionnaire

Name: _____ Birth Date: _____

Gender ❑ Male ❑ Female

Patient Notification

A Routine Eye Examination (covered by Vision Insurance Plans) covers a prescription to address the following vision conditions: Near-Sightedness, Far-Sightedness, Astigmatism and Presbyopia. All other causes of decreased vision as well as other problems and complaints (such as those listed below), may be billed medically after discussing them with the Doctor and result in higher fees.

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. (Check box)

Current Occupation _____ Years _____ Employer _____

Do you drink alcohol?	❑ No	❑ Occasional	❑ 1-2 per day	❑ 2+ per day	❑ 3+ per day
Do you smoke?	❑ No	❑ Occasional	❑ 1/2 pack per day	❑ 1-2 pack per day	❑ 2+ pack per day
Past Smoker	❑ No	❑ Yes	When did you quit smoking? _____		
Do you chew tobacco?	❑ No	❑ Yes			
Do you use nutritional supplements (vitamins, etc.)?	❑ No	❑ Yes	Do you use illegal drugs?	❑ Yes	❑ No
Have you ever been exposed to or infected with HIV?	❑ No	❑ Yes	Do you engage in regular exercise?	❑ Yes	❑ No

Review of Systems - Do you currently have any problems in the following areas:

Constitutional Symptoms			**Urinary**			**Psychiatric**		
Fever	❑ Yes	❑ No	Flomax Use	❑ Yes	❑ No	Memory Loss	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Depression	❑ Yes	❑ No
Other	❑ Yes	❑ No	Urinary Conditions/Symptoms	❑ Yes	❑ No	Other	❑ Yes	❑ No
Ear, Nose, Throat, Mouth			Other	❑ Yes	❑ No	**Endocrine**		
Hearing Loss	❑ Yes	❑ No	**Musculoskeletal**			Diabetes	❑ Yes	❑ No
Sinus Disorders	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Other	❑ Yes	❑ No	Muscle/Joint/Back Pain	❑ Yes	❑ No	Other	❑ Yes	❑ No
Cardiovascular			Other	❑ Yes	❑ No	**Blood**		
Atrial Fibrillation	❑ Yes	❑ No	**Skin**			Anemia	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Cholesterol	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No	Rash/Itching	❑ Yes	❑ No	Other	❑ Yes	❑ No
Stroke/TIA	❑ Yes	❑ No	Rosacea	❑ Yes	❑ No	**Allergic/Immunologic**		
Other	❑ Yes	❑ No	Shingles	❑ Yes	❑ No	Seasonal Allergies	❑ Yes	❑ No
Respiratory			Skin Cancer	❑ Yes	❑ No	Lupus	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Other	❑ Yes	❑ No	Other	❑ Yes	❑ No
Emphysema/COPD	❑ Yes	❑ No	**Neurological**			**Maternity**		
Shortness of breath	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Pregnant	❑ Yes	❑ No
Other	❑ Yes	❑ No	Frequent Headaches	❑ Yes	❑ No	Nursing	❑ Yes	❑ No
Gastrointestinal			Convulsions/Seizure	❑ Yes	❑ No	Other Conditions	❑ Yes	❑ No
Intestinal Conditions	❑ Yes	❑ No	Other	❑ Yes	❑ No			
Other	❑ Yes	❑ No						

Eye Diseases - Are you currently experiencing any of the following:

Amblyopia (Lazy Eye)	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Blepharitis (Inflamation of the Eyelids)	❑ Yes	❑ No	Glaucoma Suspect	❑ Yes	❑ No
Blindness	❑ Yes	❑ No	High Risk Medication	❑ Yes	❑ No
Cataract(s)	❑ Yes	❑ No	Macular Degeneration	❑ Yes	❑ No
Color Blindness	❑ Yes	❑ No	PVD (Post Vitreous Detachment)	❑ Yes	❑ No
Diabetic Retinopathy	❑ Yes	❑ No	Retinal Detachment	❑ Yes	❑ No
Dry Eye Syndrome	❑ Yes	❑ No	Strabismus (Eye Turn)	❑ Yes	❑ No
Eye Injuries	❑ Yes	❑ No	Other	❑ Yes	❑ No

Family History

Eye Diseases			Relationship to Patient	Systemic Diseases			Relationship to Patient
Amblyopia (Lazy Eye)	❑ Yes	❑ No		Arthritis	❑ Yes	❑ No	
Blindness	❑ Yes	❑ No		Cancer	❑ Yes	❑ No	
Cataract(s)	❑ Yes	❑ No		Diabetes	❑ Yes	❑ No	
Color Blindness	❑ Yes	❑ No		Heart Disease	❑ Yes	❑ No	
Eye Tumors	❑ Yes	❑ No		High Blood Pressure	❑ Yes	❑ No	
Glaucoma	❑ Yes	❑ No		Kidney Disease	❑ Yes	❑ No	
Glaucoma Suspect	❑ Yes	❑ No		Lupus	❑ Yes	❑ No	
Macular Degeneration	❑ Yes	❑ No		Stroke	❑ Yes	❑ No	
Retinal Detachment	❑ Yes	❑ No		Thyroid Disease	❑ Yes	❑ No	
Strabismus (Eye Turn)	❑ Yes	❑ No		Other Diseases	❑ Yes	❑ No	
Other Eye Condition	❑ Yes	❑ No					

Current Eye Symptoms - Are you currently experiencing any of the following:

Asthenopic			Eye Pain or Soreness	❑ Yes	❑ No	Blurred Vision Near	❑ Yes	❑ No
Glare Sensitivity	❑ Yes	❑ No	Foreign Body Sensation	❑ Yes	❑ No	Distorted Vision	❑ Yes	❑ No
Headaches	❑ Yes	❑ No	Infection of Eye Lid	❑ Yes	❑ No	Double Vision	❑ Yes	❑ No
Light Sensitivity	❑ Yes	❑ No	Itching	❑ Yes	❑ No	Flashes of lights	❑ Yes	❑ No
Tired Eyes	❑ Yes	❑ No	Mucous	❑ Yes	❑ No	Floaters or Spots	❑ Yes	❑ No
Physiologic			Ptosis (Droopy Eyelid)	❑ Yes	❑ No	Fluctuating Vision	❑ Yes	❑ No
Burning	❑ Yes	❑ No	Redness	❑ Yes	❑ No	Loss of Central Vision	❑ Yes	❑ No
Dryness	❑ Yes	❑ No	Sandy or Gritty Feeling	❑ Yes	❑ No	Loss of Side Vision	❑ Yes	❑ No
Epiphora (Watery Eyes)	❑ Yes	❑ No	**Visual Symptoms**			Loss of Vision	❑ Yes	❑ No
Eyelid Swelling	❑ Yes	❑ No	Blurred Vision Distance	❑ Yes	❑ No	Other	❑ Yes	❑ No

Medical History

Do you have any allergies? ❑ Eyes ❑ Other _____

Do you have any allergies to medications? Yes ❑ No ❑ If yes, please list medications: _____

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

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

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

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

Type of contact lenses? ❑ Rigid ❑ Soft ❑ Extended ❑ Other Are they comfortable? ❑ Yes ❑ No

Do you over wear your contacts? ❑ Yes ❑ No

Do you sleep in your contacts? ❑ Yes ❑ No

If so, How long until you take them out of your eyes? _____

I have reviewed my previous Medical History Questionnaire and there are no changes.

I have initialed/dated any changes from my previous visit above and below.

Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date

Our doctors routinely perform pupillary dilations and visual field testing. These tests allow our doctors to rule out retinal disease and check for Cataracts, Macular Degeneration, Glaucoma, and other visual pathway diseases that may lead to loss of sight. Our doctors may find it necessary to run additional diagnostic tests, which may not be covered by your insurance and additional fee for some of these diagnostic tests may apply. This service may not be covered by some insurance plans.

❑ OK to perform tests today ❑ I will reschedule these tests ❑ I will follow the doctor's recommendation

Professional fees are due upon completion of services and are non refundable.

Thank you for the priviledge of allowing Nationwide Optometry to take care of your eye health and vision needs.

Patient/Guardian Signature _____ Date _____

NATIONWIDE OPTOMETRY