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

Have you ever been exposed to or infected with HIV? ❑ No ❑ Yes

Do you use illegal drugs? ❑ Yes ❑ No

Do you engage in regular exercise? ❑ Yes ❑ No

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

Constitutional Symptoms

Fever ❑ Yes ❑ No

Fatigue ❑ Yes ❑ No

Other ❑ Yes ❑ No

Ear, Nose, Throat, Mouth

Hearing Loss ❑ Yes ❑ No

Sinus Disorders ❑ Yes ❑ No

Other ❑ Yes ❑ No

Cardiovascular

Atrial Fibrillation ❑ Yes ❑ No

Heart Disease ❑ Yes ❑ No

Hypertension ❑ Yes ❑ No

Stroke/TIA ❑ Yes ❑ No

Other ❑ Yes ❑ No

Respiratory

Asthma ❑ Yes ❑ No

Emphysema/COPD ❑ Yes ❑ No

Shortness of breath ❑ Yes ❑ No

Other ❑ Yes ❑ No

Gastrointestinal

Intestinal Conditions ❑ Yes ❑ No

Other ❑ Yes ❑ No

Urinary

Flomax Use ❑ Yes ❑ No

Kidney Disease ❑ Yes ❑ No

Urinary Conditions/Symptoms ❑ Yes ❑ No

Other ❑ Yes ❑ No

Musculoskeletal

Arthritis ❑ Yes ❑ No

Muscle/Joint/Back Pain ❑ Yes ❑ No

Other ❑ Yes ❑ No

Skin

Herpes ❑ Yes ❑ No

Rash/Itching ❑ Yes ❑ No

Rosacea ❑ Yes ❑ No

Shingles ❑ Yes ❑ No

Skin Cancer ❑ Yes ❑ No

Other ❑ Yes ❑ No

Neurological

Multiple Sclerosis ❑ Yes ❑ No

Frequent Headaches ❑ Yes ❑ No

Convulsions/Seizure ❑ Yes ❑ No

Other ❑ Yes ❑ No

Psychiatric

Memory Loss ❑ Yes ❑ No

Depression ❑ Yes ❑ No

Other ❑ Yes ❑ No

Endocrine

Diabetes ❑ Yes ❑ No

Thyroid Disease ❑ Yes ❑ No

Other ❑ Yes ❑ No

Blood

Anemia ❑ Yes ❑ No

Cholesterol ❑ Yes ❑ No

Other ❑ Yes ❑ No

Allergic/Immunologic

Seasonal Allergies ❑ Yes ❑ No

Lupus ❑ Yes ❑ No

Other ❑ Yes ❑ No

Maternity

Pregnant ❑ Yes ❑ No

Nursing ❑ Yes ❑ No

Other Conditions ❑ Yes ❑ No

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

Amblyopia (Lazy Eye) ❑ Yes ❑ No

Blepharitis (Inflamation of the Eyelids) ❑ Yes ❑ No

Blindness ❑ Yes ❑ No

Cataract(s) ❑ Yes ❑ No

Color Blindness ❑ Yes ❑ No

Diabetic Retinopathy ❑ Yes ❑ No

Dry Eye Syndrome ❑ Yes ❑ No

Eye Injuries ❑ Yes ❑ No

Glaucoma ❑ Yes ❑ No

Glaucoma Suspect ❑ Yes ❑ No

High Risk Medication ❑ Yes ❑ No

Macular Degeneration ❑ Yes ❑ No

PVD (Post Vitreous Detachment) ❑ Yes ❑ No

Retinal Detachment ❑ Yes ❑ No

Strabismus (Eye Turn) ❑ 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

- Glare Sensitivity ❑ Yes ❑ No
- Headaches ❑ Yes ❑ No
- Light Sensitivity ❑ Yes ❑ No
- Tired Eyes ❑ Yes ❑ No

Physiologic

- Burning ❑ Yes ❑ No
- Dryness ❑ Yes ❑ No
- Epiphora (Watery Eyes) ❑ Yes ❑ No
- Eyelid Swelling ❑ Yes ❑ No
- Eye Pain or Soreness ❑ Yes ❑ No
- Foreign Body Sensation ❑ Yes ❑ No
- Infection of Eye Lid ❑ Yes ❑ No
- Itching ❑ Yes ❑ No
- Mucous ❑ Yes ❑ No
- Ptosis (Droopy Eyelid) ❑ Yes ❑ No
- Redness ❑ Yes ❑ No
- Sandy or Gritty Feeling ❑ Yes ❑ No

Visual Symptoms

- Blurred Vision Distance ❑ Yes ❑ No
- Blurred Vision Near ❑ Yes ❑ No
- Distorted Vision ❑ Yes ❑ No
- Double Vision ❑ Yes ❑ No
- Flashes of lights ❑ Yes ❑ No
- Floaters or Spots ❑ Yes ❑ No
- Fluctuating Vision ❑ Yes ❑ No
- Loss of Central Vision ❑ Yes ❑ No
- Loss of Side Vision ❑ Yes ❑ No
- Loss of Vision ❑ 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