Date: _____ **ROCHELLE EYE CARE CENTER** **Medical History Questionnaire**

Last Name:_____ First: _____ MI: _____ Sex: M F Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____ H. Phone: _____
Employer: _____ Occupation: _____ Work Phone #: _____
Primary Physician: _____ Vision Ins: _____ Medical Ins: _____ SSN: _____-_____-_____

If patient is a minor, please provide the following information:
Responsible Party:_____ Birth Date:_____ SSN:_____-_____-_____

Address:_____ City:_____ State:_____ Zip:_____ Relation:_____

MEDICAL HISTORY

Are you allergic to any medications? ☐ No ☐ Yes If yes, Explain: _____
_____
_____

List any medications you take (include oral contraceptives, aspirin, over the counter and home remedies)._____
_____
_____

List all major injuries, surgeries and hospitalizations: _____
_____

If female, are you pregnant or nursing? ☐ No ☐ Yes _____

Do you wear glasses? ☐ No ☐ Yes. If yes, how old are the lenses? _____ When do you wear them? _____

Do you wear contact lenses? ☐ No ☐ Yes. If yes, how old are your present lenses? _____ Are they comfortable? ☐ No ☐ Yes

Type of contact lenses: (please circle all the apply) Rigid, Gas Perm., Soft, Extended Wear, Daily Wear, Bifocals, Disposable Schedule: daily, weekly, 2-week, monthly, other.

Personal and Family History: Please check any of the following that apply to you personally (Self) or a family member (Fam) or blood relative:

Disease/Condition	Self	Fam	**Relationship**
Arthritis	☐	☐	_____
Blindness	☐	☐	_____
Cancer	☐	☐	_____
Cataracts	☐	☐	_____
Crossed or Lazy Eyes	☐	☐	_____
Diabetes	☐	☐	_____
Glaucoma	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detach./Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Sleep Disorder	☐	☐	_____

THIS SECTION FOR DOCTOR'S USE ONLY

Reviewed By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____

REVIEW OF SYSTEMS

Do you have any problems in the following areas? Please check any that apply:

SYSTEM	**EXPLAIN**
Bones, Joints and Muscles:	
Pain	☐ _____
Rheumatoid arthritis	☐ _____
Constitutional: weight loss/gain fever	☐ _____
Ears, Nose, Mouth, Throat:	
Allergies/Hay fever	☐ _____
Sinus congestion/post-nasal drip	☐ _____
Chronic cough	☐ _____
Dry mouth/throat	☐ _____
Eyes:	
Blurry Vision	☐ _____
Chronic infection of eyes or lids	☐ _____
Distorted vision/Halos	☐ _____
Double Vision	☐ _____
Dryness	☐ _____
Eye Pain or Soreness	☐ _____
Flashes/Floaters/Spots in Vision	☐ _____
Foreign Body Sensation	☐ _____
Glare/Light sensitivity	☐ _____
Itching/Burning	☐ _____
Mucous Discharge	☐ _____
Redness	☐ _____
Sandy/Gritty Feeling	☐ _____
Tired eyes/Eye Strain	☐ _____
Gastrointestinal: Diarrhea or Constipation	☐ _____
Genitourinary: (genitals, kidney, bladder)	☐ _____
Integumentary: Skin	
Lymphatic/Hemotalogic	
Anemia	☐ _____
Bleeding problems	☐ _____
Neurologic:	
Headaches/Migraines	☐ _____
Seizures	☐ _____
Psychiatric	
Respiratory:	
Asthma	☐ _____
Chronic Bronchitis	☐ _____
Emphysema	☐ _____

Social History: This information is kept strictly confidential. However, you may discuss this with the doctor: Yes, I would like to discuss this part with the doctor. Do you drive? ☐ No ☐ Yes. If yes, do you have any vision difficulty when driving? ☐ No ☐ Yes. If yes, When? _____

Do you use tobacco? ☐ No ☐ Yes. If yes type/amount/how long?
_____

Have you been exposed to or infected with:
☐ Gonorrhea, ☐ Hepatitis, ☐ HIV, ☐ Syphilis