

Medical History Questionnaire

Name: _____ Phone # _____ Today's Date ____/____/____
 Address: _____ Cell Phone# _____ Last Eye Exam ____/____/____
 _____ ZIP Code _____ Birth Date: ____/____/____ Age _____
 Occupation: _____ Social Security # ____/____/____ Last Medical Exam ____/____/____
 Average Hours Per Day on a Computer: _____ *E-Mail Address: _____ (strictly confidential)
 Name of Insurance Company: **Medical** _____ ID # _____ **Vision** _____

Please List All Hobbies, Crafts, Sports, Recreational Activities, or Specialty Visual Tasks :

How did you hear about us (please be specific. We like to **reward our referrals!***) _____
 *ask us how!

Medical History

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

Please list all medications you are presently taking and their doses. If you have a list, please present it now to be photocopied. (Please include oral contraceptives, aspirin, OTC meds, home remedies, and vitamin supplements):

Medication: _____ Dose: _____ # Times/Day: _____ How Long: _____
 Medication: _____ Dose: _____ # Times/Day: _____ How Long: _____
 Medication: _____ Dose: _____ # Times/Day: _____ How Long: _____
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Please list all major surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? Yes No. If yes, Congratulations! How many months Pregnant? _____

Do you wear Contact Lenses? Yes No. If yes, how old are your present pair of lenses? _____

Type of Contacts: RGP Extended Wear Disposable. Are they comfortable? No Yes. Brand _____

*If you do not wear contact lenses, would you like to try a Complimentary Pair of contact lenses? Yes No

*Are you interested in LASIK surgery? Yes No

Family Medical and Ocular History

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

<u>Disease/ Condition</u>	<u>No</u>	<u>Yes</u>	<u>?</u>	<u>Relationship to you.</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____				_____

* Please turn the page over and complete side two *

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).

Do you use Tobacco products, drink alcohol, or use illegal drugs? No Yes.

* If yes, list the type/ amount/ how long _____

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

Review Of Systems

Do you currently, or have had any problems in the following areas:

<u>System</u>	<u>No</u>	<u>Yes</u>	<u>?</u>		<u>No</u>	<u>Yes</u>	<u>?</u>
Constitutional							
Fever, Weight Loss/ Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Neurological							
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eyes							
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Endocrine							
Thyroid/ Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Ears, Nose, Mouth, Throat			
				Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Respiratory			
				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular / Cardiovascular			
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Gastrointestinal			
				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Genitourinary			
				Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bones/ Joints/ Muscles			
				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Lymphatic/ Hematologic			
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for your time! *This information is vital to Dr. Hoffman's comprehensive examinations and allows us to better serve your needs.*

OFFICE USE ONLY:

Review Date: By: Review Date: By: Review Date: By: Review Date: By:

 Doctor's Signature Date Tablet 10/08