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: **Medica**l_____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:_____

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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:

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 _____				_____

*** 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:

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	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/ Other Glands	☐	☐	☐

System	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	☐	☐	☐
Allergic / Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

***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

_____ _____