

**Medical History Questionnaire** (Conejo Family Eyecare 299 W. Hillcrest Drive, TO, CA 91360)

Do you have any allergies to medications?  no  yes If yes, please explain \_\_\_\_\_

Please list any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): \_\_\_\_\_

When was your last Eye Exam? \_\_\_\_\_ Do you wear glasses? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_

Have you ever had any injury or surgeries to your eyes? \_\_\_\_\_

Are you pregnant or nursing? \_\_\_\_\_

**Review of Systems:**

Do you currently, have you ever, or do you have family history (parents, grandparents, siblings, aunts/uncles) of any problems in the following areas? Any boxes left unchecked are assumed negative.

	Self	Family	Relationship		Self	Family	Relationship
<b><u>EYES:</u></b>				<b><u>EARS, NOSE, MOUTH, THROAT:</u></b>			
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies	<input type="checkbox"/>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sinusitis	<input type="checkbox"/>		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Cough	<input type="checkbox"/>		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dry Throat/Mouth	<input type="checkbox"/>		
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	<b><u>ENDOCRINE:</u></b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>			<b><u>RESPIRATORY:</u></b>			
Loss of Side Vision	<input type="checkbox"/>			Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>			Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters	<input type="checkbox"/>			<b><u>IMMUNOLOGIC CONDITIONS:</u></b>			
Redness	<input type="checkbox"/>			Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itchiness	<input type="checkbox"/>			HIV/AIDS	<input type="checkbox"/>		
Burning	<input type="checkbox"/>			<b><u>CONSTITUTIONAL:</u></b>			
Excess Tearing	<input type="checkbox"/>			Fever	<input type="checkbox"/>		
Glare Sensitivity	<input type="checkbox"/>			Weight Loss/Gain	<input type="checkbox"/>		
Eye Pain/Soreness	<input type="checkbox"/>			<b><u>BONES/JOINTS/MUSCLES:</u></b>			
Chronic Infection	<input type="checkbox"/>			Arthritis	<input type="checkbox"/>		
Tired Eyes	<input type="checkbox"/>			Joint Pain	<input type="checkbox"/>		
<b><u>NEUROLOGICAL:</u></b>				Muscle Pain	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	<b><u>GENITOURINARY:</u></b>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney	<input type="checkbox"/>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bladder	<input type="checkbox"/>		
<b><u>VASCULAR/CARDIOVASCULAR:</u></b>				Genitals	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<b><u>LYMPHATIC/HEMATOLOGIC:</u></b>			
Heart Pain	<input type="checkbox"/>			Anemia:	<input type="checkbox"/>		
Heart Attack/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	<b><u>GASTROINTESTINAL:</u></b>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Constipation	<input type="checkbox"/>		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<b><u>SKIN:</u></b>	<input type="checkbox"/>		
<b><u>CANCER:</u></b>				<b><u>PSYCHIATRIC:</u></b>	<input type="checkbox"/>		
Breast:	<input type="checkbox"/>						

**Social History**

Do you drive?  yes  no

Do you use tobacco products  yes  no

Do you drink alcohol?  yes  no

Do you use illegal drugs?  yes  no

If yes, type and amount \_\_\_\_\_

Reviewed by Doctor:

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Jason Griffith, OD