ERIC S. HUSSEY, O.D., FCOVD / Optometry Offices, P.S.

Medical History Questionnaire Today's Date: _____

Name: _____ Birthdate: _____

Last Medical Exam: _____ Last Eye Exam: _____

What allergies to medications do you have? _____

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

_____

_____

List all major injuries, surgeries, and hospitalizations you have had: _____

_____

Circle any of the following that you have had: crossed eyes lazy eye drooping eyelid prominent eyes glaucoma retinal disease cataracts eye infections _____ eye injuries _____

Are you pregnant or nursing? (circle one) yes no

Do you wear glasses? (circle one) yes no

If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? (circle one) yes no Are they comfortable? yes no

If yes, how old is your present pair of lenses? _____

Type of contact lenses: (circle one) Rigid Soft Extended Wear Other

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

Disease/Condition	Circle One	Relationship To You
Blindness	yes no not sure	_____
Cataract	yes no not sure	_____
Crossed Eyes	yes no not sure	_____
Glaucoma	yes no not sure	_____
Macular Degeneration	yes no not sure	_____
Retinal Detachment	yes no not sure	_____
Retinal Disease	yes no not sure	_____
Arthritis	yes no not sure	_____
Cancer	yes no not sure	_____
Diabetes	yes no not sure	_____
Heart Disease	yes no not sure	_____
High Blood Pressure	yes no not sure	_____
Kidney Disease	yes no not sure	_____
Thyroid Disease	yes no not sure	_____
Other: _____	yes no not sure	_____

Social History

Do you drive? (circle one) yes no

If yes, do you have visual difficulty when driving? (circle one) yes no

If yes, please describe: _____

Do you use tobacco products? (circle one) yes no

If yes, type/amount/how long: _____

Do you drink alcohol? (circle one) yes no
If yes, type/amount/how long: _____
Do you use illegal drugs? (circle one) yes no
If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: (circle all which apply)
Gonorrhea Syphilis HIV Hepatitis

Review Of Systems: Do you currently, or have you ever had any problems in the following areas? If yes, please explain and list medications.

System	Circle One	Explain/Medications
Skin:	yes no not sure	_____
Neurologic:		
Headaches	yes no not sure	_____
Migraines	yes no not sure	_____
Seizures	yes no not sure	_____
Eyes:		
Loss of Vision	yes no not sure	_____
Blurred Vision	yes no not sure	_____
Distorted Vision	yes no not sure	_____
Lost Side Vision	yes no not sure	_____
Double Vision	yes no not sure	_____
Discharge	yes no not sure	_____
Chronic Infection	yes no not sure	_____
Redness	yes no not sure	_____
Dry/Sandy/Gritty	yes no not sure	_____
Itching/Burning	yes no not sure	_____
Excess Tearing	yes no not sure	_____
Light Sensitivity	yes no not sure	_____
Eye Pain	yes no not sure	_____
Styes	yes no not sure	_____
Flashes/Floaters	yes no not sure	_____
Tired Eyes	yes no not sure	_____
Ears, Nose, Mouth, Throat:		
Allergy/Hayfever	yes no not sure	_____
Sinus Problems	yes no not sure	_____
Chronic Cough	yes no not sure	_____
Respiratory:		
Asthma/Chronic Bronchitis	yes no not sure	_____
Emphysema	yes no not sure	_____
General:		
Diabetes	yes no not sure	_____
Heart Disease	yes no not sure	_____
Blood Pressure	yes no not sure	_____

Other: _____