

Bellevue Eyecare Center

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: ____ / ____ / ____
Mr/Mrs/Ms/Dr/Rev
 Address: _____ Phone: _____
 City: _____ Zip: _____ Last Eye Exam: ____ / ____ / ____
 Guardian (If Applicable): _____ Last Medical Exam: ____ / ____ / ____
 Date of Birth ____/____/____ Last 4 Digits of Social Security # ____ _ _ _ _
 Email Address: _____ Occupation _____ Medical Doctor Name & Number: _____
 Preferred Pharmacy: _____

Reason for Visit: Yearly Exam Need Glasses/contacts Medical Eye Problem Other

Medical History

Are you allergic to any medications? no yes If yes, explain _____

List any medications you take or attach list: _____

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

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes
 Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____
 Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____
 Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no
 Brand Name: _____ Right Eye Power: _____ Left Eye Power: _____

Family History

Select all that apply (parents, grandparents, siblings, children; living or deceased) for the following conditions

DISEASE/CONDITION:	RELATIONSHIP TO YOU:
Blindness	<input type="checkbox"/> _____
Cataract	<input type="checkbox"/> _____
Crossed Eyes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Detachment/Disease	<input type="checkbox"/> _____
Arthritis	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____
Kidney Disease	<input type="checkbox"/> _____
Lupus	<input type="checkbox"/> _____
Thyroid Disease	<input type="checkbox"/> _____
Other _____	<input type="checkbox"/> _____

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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 directly with the doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

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

Review of Systems

Select all that apply:

SYSTEM

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

Mucous Discharge

Redness

Sandy or Gritty Feeling

Itching

Burning

Foreign Body Sensation

Excess Tearing/Watering

Glare/Light Sensitivity

Eye Pain or Soreness

Chronic Infection of Eye or Lid

Sties or Chalazion

Flashes/Floaters in Vision

Tired Eyes

ENDOCRINE

Thyroid/Other Glands

Other conditions not listed

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

If you answered YES to any of the above please explain:
