20(15 EyeCare™
Focusing on the Future

Medical History Questionnaire

Date:_____

Name: _____ Birthdate:_____/_____/_____ Age:_____

Address:_____ Phone number:_____

City:_____ State:_____ Zip:_____ Occupation: _____

Email:_____ Optometric Physician:_____

Guardian (*if applicable*): _____ Last Eye Exam: _____

Referral: How did you find us? ☐ Insurance Website ☐ Live/Work Close By ☐Family/Friend_____

Chief Complaint - Reason for Eye Exam: *(Please check **ALL** that apply)*_____

☐ Ocular Wellness Exam / Annual Eye Exam: ☐Glasses ☐ Contacts ☐ Refractive Surgery Evaluation

☐ Contact Lens Exam: Evaluation, fitting, and follow-up - (*The additional cost may* **NOT** *be covered by your Vision Plan.*)

Do you wear contacts? ☐ Yes ☐ No ☐ I want to discuss contact lens options.

Lens Type: ☐ Daily Disposable ☐ 2-Week Disposable ☐ 1-Month Disposable ☐RGP Contacts (gas permeable)

☐ Medical Eye Exam:_____

☐ Blurred Vision at: ☐ Distance ☐ Computer ☐ Near ☐ All Distances

☐ Red Eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Discharge ☐ Eye Drops _____

☐ Dry Eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Burning ☐Eye Drops_____

☐ Allergy Eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Itching ☐Eye Drops_____

☐ Headaches: ☐ With Computer Use ☐ In Afternoon ☐ Upon Awakening

☐ Diabetic Ocular Exam ☐ Last A1C_____ ☐ Last Sugar_____ ☐ Diabetic Retinopathy

Medical History: *(This is kept strictly confidential)*

General Health Status: ☐ Excellent ☐ Good ☐Fair ☐ Poor

Do you smoke? ☐Yes ☐ No Do you drink Alcohol? ☐ Yes ☐ No Do you use illicit drugs? ☐Yes ☐No

Females: Are you pregnant? ☐ Yes ☐No Are you nursing? ☐Yes ☐No

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

Do you have: ☐ Diabetes ☐ High Blood Pressure ☐ Autoimmune Disease ☐ Thyroid Disorders ☐ Cancer

Please list names and doses of CURRENT medications you take:

Medication	Dosage	Condition *(Diabetes, Hypertension, etc.)*

Please list any recent injuries, surgeries, and/or hospitalizations:

Date	Description (*Details if applicable*)

Review of Systems (*please check* **ALL** *that apply*)

Eyes

☐ Blurred Vision ☐ Red Eyes ☐ Poor Night Vision ☐ Itchy Eyes ☐ Dry Eyes ☐ Eye Strain ☐ Excessive Tearing
☐ Flashes of light ☐ Floaters ☐ Light Sensitivity ☐ Discharge ☐ Double Vision ☐ Eye Pain ☐ Loss of Vision

Ears, Nose, Throat, and Mouth

☐ Allergies ☐ Ear Ache ☐ Nasal Congestion ☐ Cough ☐ Dry Mouth ☐ Hearing Loss

Cardiovascular

☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Problems

Endocrine

☐ Diabetes ☐ Thyroid ☐ Pituitary ☐ Graves Disease

Gastrointestinal

☐ Crohn's/Colitis ☐ Celiac Disease ☐ Diarrhea/Constipation

Dermatologic (Skin)

☐ Acne Rosacea ☐ Psoriasis ☐ Rashes ☐ Growths

Genitourinary

☐ Frequent Urination ☐ Impotency ☐ Kidney Disease ☐ Bladder

Musculoskeletal/Autoimmune

☐ Arthritis ☐ Sjogrens ☐ Lupus ☐ MS ☐ Syphilis

Lymphatic/Hematologic

☐ Anemia ☐ Bleeding Disorders ☐ Hepatitis ☐ AIDS ☐ HIV

Respiratory

☐ Asthma ☐ Bronchitis ☐ Emphysema

Neurological

☐ Headaches ☐ Migraines ☐ Seizures ☐ Ocular Migraines

Psychiatric

☐ Anxiety ☐ Depression ☐ Bipolar Disorder

Ocular History

Have you had eye surgery? ☐ Yes ☐ No If Yes- ☐ Type: _____

Have you had refractive surgery? ☐ Yes ☐ No If Yes- ☐ LASIK ☐ PRK ☐ RK When?_____

Have you ever been diagnosed with any ocular diseases? ☐ Yes ☐ No

☐ Glaucoma ☐ Macular Degeneration ☐ Ocular Allergy ☐ Hypertensive Retinopathy

☐ Cataracts ☐ Dry Eye Syndrome ☐ Diabetic Retinopathy ☐ Other: _____

Do you use eye drops? ☐ Yes ☐ No If Yes, Please List: _____

Family History (*this includes parents, grandparents, and siblings*)

Glaucoma_____ Diabetes_____
Cataracts_____ Hypertension_____
Macular Degeneration_____ Heart Disease _____
Lazy Eye/Amblyopia_____ Autoimmune Disease_____
Blindness_____ Thyroid _____

Doctor's Notes

VP

☐ P92004
☐ P92014
☐ P92012
☐ P90040
☐ P90050

MP

☐ P99201
☐ P99202
☐ P99203
☐ P99204
☐ P4074

☐ P99211
☐ P99212
☐ P99213
☐ P99214
☐ P68761

Diabetes Glaucoma
Hypertension Cataracts
High Cholesterol AMD

☐ P92310 ☐ P92083 ☐ P92250
☐ P92072 ☐ P92081

VAcEG 20/_____
VAcCL 20/_____
C/D _____ _____

F/U: 1 day 1 week 1 month_____