VISION SOURCE
Larry E. Tope, O.D.
vision care provider

To ensure the best qualtiy of care, please fill out our medical history questionaraire to the best of your ability. Thank you.

Medical History Questionnaire

Patient Information

Patient Name: _____ **Date:** ____/____/____
(First) (MI) (Last)

Preferred Name: _____ **Date of Birth:** ____/____/____ **Sex:** ☐ **Male** ☐ **Female**

Address _____ **City** _____ **State** _____ **ZIP** _____

Cell Phone _____ **Home Phone** _____ **Phone (Other)** _____

Check appropriate box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

What is your height? _____ **What is your weight?** _____

Ethnicity: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** **Race:** _____

What is the main reason (vision complaint) for your eye examination today? _____

_____

_____

_____

Insurance Information

Medical

Insurance Company _____

Name of Person Insured _____

Relationship to Patient _____

Vision

Insurance Company _____

Name of Person Insured _____

Last four digits of Person insured social number

_____

Relationship to Patient _____

Eye/Medical Exam History

Last Eye Exam: ____/____/____ **Doctor:** _____ **City/Office:** _____

Last Physical Exam: ____/____/____ **Doctor/PA/NP:** _____ **City/Office:** _____

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Review of Systems

Do you currently have any problems in the following areas? Please mark all that apply.

Constitution

- ☐ none
- ☐ fever
- ☐ malaise
- ☐ weight loss
- ☐ weight gain
- ☐ other _____

Integumentary

- ☐ none
- ☐ skin lesions
- ☐ acne
- ☐ adult acne
- ☐ rash
- ☐ psoriasis
- ☐ edema
- ☐ eczema
- ☐ cancer
- ☐ rosacea
- ☐ other _____

Eyes

- ☐ none
- ☐ shingles affecting eyes
- ☐ styes/chalazion
- ☐ double vision
- ☐ amblyopia right eye
- ☐ amblyopia left eye
- ☐ blurred vision
- ☐ blepharitis
- ☐ blepharochalasis
- ☐ cataracts
- ☐ chronic blepharitis
- ☐ corneal dystrophy
- ☐ dermatochalasis
- ☐ diabetic retinopathy
- ☐ distorted vision
- ☐ dry eyes
- ☐ ectropion
- ☐ entropion

(Eyes cont.)

- ☐ epiphora
- ☐ fatigue/asthenopia
- ☐ flashes
- ☐ floaters
- ☐ glaucoma-open angle
- ☐ glaucoma-narrow angle
- ☐ glaucoma
- ☐ ocular hypertension
- ☐ herpes simplex
- ☐ legally blind
- ☐ light sensitivity
- ☐ loss of vision
- ☐ macular degeneration
- ☐ peripheral loss of vision
- ☐ trichiasis
- ☐ other _____

Neurological

- ☐ none
- ☐ Alzheimer's
- ☐ epilepsy
- ☐ migraine headache
- ☐ multiple sclerosis
- ☐ myasthenia gravis
- ☐ Parkinson's Disease
- ☐ seizures
- ☐ other _____

Endocrine

- ☐ none
- ☐ no diabetes
- ☐ diabetes
- ☐ IDDM (Insulin-dependent diabetes mellitus)
- ☐ NIDDM (noninsulin-dependent diabetes mellitus)
- ☐ kidney disease

(Endocrine cont.)

- ☐ chronic kidney disease
- ☐ acute renal failure
- ☐ kidney stones
- ☐ Polycystic kidney disease
- ☐ on dialysis
- ☐ 3x per week performed at treatment center
- ☐ home dialysis
- ☐ completed at home independently
- ☐ peritoneal dialysis
- ☐ home hemodialysis
- ☐ kidney transplant candidate
- ☐ thyroid disease
- ☐ pituitary gland dysfunction
- ☐ adrenal gland dysfunction
- ☐ other _____

Ear, Nose, Mouth, Throat

- ☐ none
- ☐ allergies/hay fever
- ☐ hearing aids
- ☐ sinus congestion
- ☐ runny nose
- ☐ post-nasal drip
- ☐ chronic cough
- ☐ dry throat/mouth
- ☐ other _____

Respiratory

- ☐ none
- ☐ asthma
- ☐ chronic bronchitis
- ☐ emphysema
- ☐ other _____

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Gastrointestinal

- ☐ none
- ☐ acid reflux
- ☐ gerd
- ☐ diarrhea
- ☐ hiatal hernia
- ☐ other _____

Vascular/Cardiovascular

- ☐ none
- ☐ elevated cholesterol
- ☐ high blood pressure
- ☐ congestive heart disease
- ☐ vascular disease
- ☐ other _____

Genitourinary

- ☐ none
- ☐ kidney failure
- ☐ bladder
- ☐ STD
- ☐ prostate

(Genitourinary cont.)

- ☐ pregnancy
- ☐ nursing
- ☐ other _____

Musculoskeletal

- ☐ none
- ☐ ankylosing spondylitis
- ☐ arthritis
- ☐ joint pain
- ☐ juvenile rheumatoid arthritis
- ☐ muscle pain
- ☐ Myasthenia Gravis
- ☐ osteoarthritis
- ☐ osteoporosis
- ☐ rheumatoid arthritis
- ☐ other _____

Lymphatic/Hematologic

- ☐ none
- ☐ bleeding problems

(Lymphatic/Hematologic cont.)

- ☐ lymphadenopathy
- ☐ other _____

Immunologic

- ☐ none
- ☐ HIV
- ☐ chemotherapy
- ☐ other _____

Psychiatric

- ☐ none
- ☐ depression
- ☐ ADD (Attention-deficit disorder)
- ☐ ADHD (Attention-deficit/hyperactivity disorder)
- ☐ anxiety
- ☐ other _____

Past, Family and Social History

Past Medical History

Past Ocular History:

Please mark all that apply

History:

- ☐ no significant ocular history
- ☐ infection
- ☐ trauma
- ☐ injury
- ☐ surgery
- ☐ no history of amblyopia or strabismus

Lid Infections:

- ☐ chronic marginal blepharitis

(Lid Infections cont.)

- ☐ blepharitis
- ☐ styes
- ☐ hordeolum

Cataracts:

- ☐ right eye
- ☐ left eye
- ☐ both eyes

Crossed Eyes:

- ☐ lazy eye
- ☐ drooping eyelid

(Crossed Eyes cont.)

- ☐ prominent eyes

Glaucoma:

- ☐ right eye
- ☐ left eye
- ☐ both eyes

Elevated Intraocular Pressure:

- ☐ right eye
- ☐ left eye
- ☐ both eyes

Macular Degeneration:

- ☐ right eye
- ☐ left eye
- ☐ both eyes

Other Conditions:

- ☐ Cataract Extraction
- ☐ Refractive surgery
- ☐ _____
- ☐ _____

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Past Personal Medical History:

Please mark all that apply.

Conditions:

- ☐ No significant past medical history
- ☐ Cancer
  - Type: _____
- ☐ Diabetes
  - Type: _____
- ☐ Heart Disease
  - Type: _____
- ☐ Stroke
- ☐ Other _____

Surgeries:

- ☐ No surgeries
- ☐ Appendix removed
- ☐ Back surgery
- ☐ Bunion surgery
- ☐ Cancer
- ☐ C-section
- ☐ Tonsillectomy
- ☐ Open heart surgery
- ☐ Heart transplant
- ☐ Hysterectomy
- ☐ Cardiac valve replacement

(Surgeries cont.)

- ☐ Endarterectomy
- ☐ Gall bladder surgery
- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Refractive surgery
- ☐ Pacemaker
- ☐ Tracheostomy
- ☐ Gastric by-pass
- ☐ Other _____

Hospitalizations:

- ☐ No hospitalizations
- ☐ To control diabetes
- ☐ For cancer
- ☐ For COPD
- ☐ Surgical admission
- ☐ Diagnostic tests
- ☐ Following stroke
- ☐ Other _____

Injuries:

- ☐ No significant injuries
- ☐ Burns
- ☐ Chemical burns
- ☐ Head injury
- ☐ Broken bones
  - Body part: _____

(Injuries cont.)

- ☐ Injury at home
- ☐ Sport injury
- ☐ Work related accident
- ☐ Fell
- ☐ Auto accident
  - Did not require hospitalization
  - Did require hospitalization
- ☐ Other _____

Immunizations:

- ☐ Has received an influenza immunization during flu season
- ☐ Has not received an influenza immunization during flu season

Pregnancies:

- ☐ Currently pregnant
- ☐ Currently nursing

Complications with pregnancy:

- ☐ Gestational diabetes
- ☐ Bed rest required
- ☐ Hypertension
- ☐ miscarriage

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Family History:

Has any member of your family had these conditions? Please mark all that apply, and write which relative (father, mother, brother, sister, maternal grandmother, maternal grandfather, paternal grandmother, paternal grandfather, uncle, aunt, nephew, niece

Ocular Conditions:

- ☐ ARMD _____
- ☐ Amblyopia _____
- ☐ Blindness _____
- ☐ Cataract _____
- ☐ Corneal dystrophy _____
- ☐ Crossed eyes _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration other than ARMD _____
- ☐ Retinal disease _____
- ☐ Retinal detachment _____
- ☐ Other _____

Systemic Conditions:

- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes- type unknown _____
- ☐ Heart disease _____
- ☐ Hypertension _____
- ☐ Kidney disease _____
- ☐ Lupus _____
- ☐ Thyroid disease _____
- ☐ Type 1 diabetes _____
- ☐ Type 2 diabetes _____
- ☐ Vascular disease _____
- ☐ Other _____

☐ No Known Family History

Social History:

Education:

- ☐ Eighth grade or less
- ☐ Some high school
- ☐ High school
- ☐ Some college
- ☐ 2-year college
- ☐ 4-year college
- ☐ GED
- ☐ Masters
- ☐ PhD
- ☐ Doctorate

Computer:

- ☐ Occasional use
- ☐ <1 hour
- ☐ 1-2 hours
- ☐ 2-5 hours
- ☐ 5-8 hours
- ☐ Over 8 hours

Driving:

How Often?

- ☐ Regularly
- ☐ Occasionally
- ☐ Daytime only
- ☐ Not driving

Visual difficulty when driving?

- ☐ No
- ☐ Yes, Explain _____

Alcohol:

- ☐ No alcohol consumption
- ☐ Once per week
- ☐ Daily
- ☐ Alcoholic
- ☐ Socially only

Tobacco Use:

- ☐ Never a smoker
- ☐ Unknown if ever smoked
- ☐ Former smoker
- ☐ Light tobacco smoker
- ☐ Every day smoker
- ☐ Heavy tobacco smoker

Illegal Drugs:

- ☐ Denies illegal drug use
- ☐ Uses recreational drugs

Exposure/infected:

- ☐ No known exposure
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Hepatitis
- ☐ HIV
- ☐ Syphilis
- ☐ Other _____

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Medication

Please list all of your medications below. This includes *prescription medications, over the counter medications, herbal medications, vitamins, minerals, nutritional supplements.* Also include the dosage of each medication and the frequency taken.

Medication	Dosage	Frequency

List All of Your Medication Allergies

List All of Your Environmental and Seasonal Allergies

Please Sign and Date

Self (The Patient) _____ Date ____/____/____

Authorized Representative _____ Date ____/____/____

If you need more space, please feel free to use the back.