Medical History Questionaire

TULMAN EYE GROUP
ADULT & PEDIATRIC OPTOMETRY
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Name: _____ Date: _____

Birth Date: _____/_____/_____ Social Security # _____/_____/_____
Month Day Year

Last Eye Doctor: _____ Last Eye Exam: _____ / _____
Month Year

Current Medical Dr(s): _____ Last Medical Exam: _____ / _____
Month Year

Medical History

Do you have any allergies including medications, food, seasonal, etc.? ☐ Yes ☐ No If yes, explain: _____

List any medications (including oral contraceptives, aspirin, over-the-counter medications, eye drops and home remedies):

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

Are you pregnant and/or nursing? ☐ Yes ☐ No

Check any of the following that you have had: ☐ Reading Difficulty ☐ Crossed Eyes ☐ Lazy Eye ☐ Glaucoma
☐ Retinal Disease ☐ Cataracts ☐ Eye Injury ☐ Macular Degeneration ☐ Other _____

Do you wear glasses? ☐ Yes ☐ No If Yes, how old is your present pair of glasses? _____
How many pair of glasses do you currently use? _____

Do you wear contact lenses? ☐ Yes ☐ No If No, Are you interested? ☐ Yes ☐ No

If Yes, how old is your present pair of contacts? _____ Do you sleep in your contact lenses? ☐ Yes ☐ No

Type of contact lenses: ☐ Gas Perm. ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Have you had cataract surgery? ☐ Yes ☐ No If Yes, ☐ R ☐ L

Have you had refractive (LASIK / PRK / RK) surgery? ☐ Yes ☐ No Interested? ☐ Yes ☐ No

At work: Do you perform fine or close-up work? ☐ Yes ☐ No Is safety protection a concern at work? ☐ Yes ☐ No
Are you outdoors all or part of the time? ☐ Yes ☐ No

Are you bothered by the glare from:
Overhead lighting? ☐ Yes ☐ No Oncoming headlights at night? ☐ Yes ☐ No A computer screen? ☐ Yes ☐ No

Do you have trouble reading signs when driving at night? ☐ Yes ☐ No

Are you sensitive to bright sunlight? ☐ Yes ☐ No

What hobbies or recreational sports do you enjoy?

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease / Condition				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/Disease	☐ Yes	☐ No	☐ Not Sure	_____
Systemic Disease / Condition				
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	_____
Lupus	☐ Yes	☐ No	☐ Not Sure	_____
Thyroid Disease	☐ Yes	☐ No	☐ Not Sure	_____
Other _____	☐ Yes	☐ No	☐ Not Sure	_____

** Please turn this form over and complete Side 2 **

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 information directly with my doctor. (Check box)

Do you drive? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you smoke? ☐ Yes ☐ No If yes, how much/how often: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much/how often: _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Chlamydia ☐ Herpes ☐ Syphillis ☐ No, I have not.

Review of Systems Do you currently. or have you ever had any problems in the following areas:

System	Yes	No	Not Sure
Cancer *(describe)*	☐	☐	☐
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Skin			
Rash/Eczema	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
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	☐	☐	☐
Stye or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Liver			
Cirrhosis	☐	☐	☐
Hepatitis	☐	☐	☐

System	Yes	No	Not Sure
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			
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Brain Injury / Stroke	☐	☐	☐
Endocrine			
Diabetes Type I / II	☐	☐	☐
Thyroid Hyper / Hypo	☐	☐	☐
Other Glands *(describe)*	☐	☐	☐
Genitourinary			
Genitals / Kidney / Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic / Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

DO NOT WRITE BELOW THIS LINE *(Doctor's Comments):*

I have reviewed this history with the patient: _____

Doctor's Signature / Date