

Date: _____

ROCHELLE EYE CARE CENTER



Medical History Questionnaire

Last Name: _____ First: _____ MI: _____ Sex: M F Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____ H. Phone: _____
Employer: _____ Occupation: _____ Work Phone #: _____
Primary Physician: _____ Vision Ins: _____ Medical Ins: _____ SSN: _____ - _____ - _____

If patient is a minor, please provide the following information:

Responsible Party: _____ Birth Date: _____ SSN: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____ Relation: _____

MEDICAL HISTORY

Are you allergic to any medications? [] No [] Yes If yes, Explain: _____

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

List all major injuries, surgeries and hospitalizations: _____

If female, are you pregnant or nursing? [] No [] Yes _____

Do you wear glasses? [] No [] Yes. If yes, how old are the lenses? _____ When do you wear them? _____

Do you wear contact lenses? [] No [] Yes. If yes, how old are your present lenses? _____ Are they comfortable? [] No [] Yes

Type of contact lenses: (please circle all the apply) Rigid, Gas Perm., Soft, Extended Wear, Daily Wear, Bifocals, Disposable Schedule: daily, weekly, 2-week, monthly, other.

Personal and Family History: Please check any of the following that apply to you personally (Self) or a family member (Fam) or blood relative:

Table with 3 columns: Disease/Condition, Self, Fam, Relationship. Rows include Arthritis, Blindness, Cancer, Cataracts, etc.

REVIEW OF SYSTEMS

Do you have any problems in the following areas? Please check any that apply:

- SYSTEM EXPLAIN
Bones, Joints and Muscles: Pain, Rheumatoid arthritis
Constitutional: weight loss/gain fever
Ears, Nose, Mouth, Throat: Allergies/Hay fever, Sinus congestion/post-nasal drip, etc.
Eyes: Blurry Vision, Chronic infection of eyes or lids, etc.
Gastrointestinal: Diarrhea or Constipation
Genitourinary: (genitals, kidney, bladder)
Integumentary: Skin
Lymphatic/Hemotologic: Anemia, Bleeding problems
Neurologic: Headaches/Migraines, Seizures
Psychiatric
Respiratory: Asthma, Chronic Bronchitis, Emphysema

THIS SECTION FOR DOCTOR'S USE ONLY

Reviewed By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____
Updated By: _____ Date: _____

Social History: This information is kept strictly confidential. However, you may discuss this with the doctor: Yes, I would like to discuss this part with the doctor. Do you drive? [] No [] Yes. If yes, do you have any vision difficulty when driving? [] No [] Yes. If yes, When? _____
Do you use tobacco? [] No [] Yes. If yes type/amount/how long? _____

Have you been exposed to or infected with:
[] Gonorrhea, [] Hepatitis, [] HIV, [] Syphilis