Enfield Eyecare Associates
MEDICAL HISTORY QUESTIONNAIRE

Please print clearly Account #: _____

Name: _____ Today's Date: _____ / _____ / _____

Address: (street) _____ Home Phone: ( ) _____

(city) _____ (state) _____ (zip code) _____ Work Phone: ( ) _____

Birthdate: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Last Eye Exam: _____ /_____ Month Year

Spouse: _____ Legal guardian: _____

Person responsible for account if different from above (name, address and phone #) _____

_____

Full Time Student ☐Yes ☐ No If yes, grade _____ Referred By: _____

Employer: _____ Employer Phone #: _____

Vision Insurance: _____Member ID #: _____ Subscriber: _____

Major Medical Ins.: _____Member ID #: _____ Subscriber: _____

Employer of Subscriber, if other than self: _____ Are referrals required? ☐ Yes ☐ No

Secondary Medical Ins.: _____Member ID#: _____ Subscriber: _____

Name of Medical Doctor or Group: _____ Dr.'s Phone: ( ) _____

Doctor's Address: (street) _____ Last Medical Exam: _____ / _____ Month Year

(city) _____ (state) _____ (zip code) _____

Current Specialist names and specialty: _____

Medical History

Do you have any allergies to medications? ☐Yes ☐ No If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
*If a list of the medications is available, please attach. ☐ None _____

_____

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

_____

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

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

Do you wear glasses? ☐Yes ☐ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐Yes ☐ No If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended wear ☐Other; Are they comfortable? ☐Yes ☐ No

Do you need safety glasses for work? ☐ Yes ☐ No

Have you ever had your eyes dilated? ☐Yes ☐ No If yes, did you have a reaction to the drops? ☐Yes ☐ No

Social History

This information is 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.

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

_____

Do you use tobacco products? ☐Yes ☐No If yes, type/amount/how long? _____

Do you drink alcohol? ☐Yes ☐No If yes, # of drinks/week? _____

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

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ No

Please turn over and complete the back side as well. Thank you.

Review of Systems *Do you currently, or have ever had any problems in the following areas?*

System	NO	YES	Not Sure
CONSTITUTIONAL			
Fever, weight loss/gain	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Blurred vision distance	☐	☐	☐
Blurred vision near	☐	☐	☐
Loss of vision	☐	☐	☐
Distorted vision/haloes	☐	☐	☐
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	☐	☐	☐
Stye or chalazion	☐	☐	☐
Flashes/floaters in vision	☐	☐	☐
Tired eyes	☐	☐	☐
Computer vision problems	☐	☐	☐
ENDOCRINE			
Thyroid/other glands	☐	☐	☐

	NO	YES	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			
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 have a condition that is not listed, please explain: _____

_____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	NO	YES	Not Sure	Relationship to you
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed eyes	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____