Friedman Optometry
Medical History Questionnaire

Name: ______________________________ Date: _______________

Date of Birth: ______________________________

Occupation: ____ Emergency Contact Person: __________________________

Medical Doctor: ________________________________ Emergency Telephone Number: _______________________

Doctor's Phone Number: _______________________

Last Eye Exam: _______________________________

Do you wear glasses?	☐ No	☐ Yes
Do you wear contact lenses?	☐ No	☐ Yes

If yes, how old is your current pair? _____________

If yes, how old is your current pair? _____________

Type of contact lenses: ☐ Soft ☐ Rigid ☐ Scleral ☐ Other

List all past **EYE** injuries and surgeries____

____

____

Symptoms of the EYES:	NO	YES	?
Loss of Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐

EYE Conditions:	NO	YES	?
Macular Degeneration	☐	☐	☐
Glaucoma	☐	☐	☐
Dry Eye	☐	☐	☐
Cataract	☐	☐	☐

Other Eye Conditions:________________________________

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Are there any other concerns about your eyes?

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Medical History

Are you pregnant/nursing?	☐ No	☐ Yes

List all past major surgeries:____

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Please list any known **drug allergies**: ____

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List all **medications you take** (including aspirin, over-the-counter, birth control, herbal remedy etc):

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Social History *The information is confidential. You may discuss this portion directly with the doctor if you prefer.*

Do you use tobacco products? ☐ No ☐ Yes If yes, How long: ________________________________

TURN OVER------------------------>>>>

Review of Systems

MUSCULOSKELETAL	**NO**	**YES**	**?**	**ENDOCRINE**	**NO**	**YES**	**?**
Lower Back Pain	☐	☐	☐	Thyroid/Other Glands	☐	☐	☐
Joint Pain	☐	☐	☐	Diabetes	☐	☐	☐
PSYCHIATRIC	☐	☐	☐	**GASTROINTESTINAL**	**NO**	**YES**	**?**
Clinical Depression	☐	☐	☐	Irritable Bowel Syndrome	☐	☐	☐
Bipolar Disorder	☐	☐	☐	**HEMATOLOGIC**	**NO**	**YES**	**?**
Schizophrenia	☐	☐	☐	Anemia	☐	☐	☐
RESPIRATORY	**NO**	**YES**	**?**	**IMMUNOLOGIC**	**NO**	**YES**	**?**
Asthma	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Emphysema	☐	☐	☐	Lupus	☐	☐	☐
COPD	☐	☐	☐	Sjogren's Syndrome	☐	☐	☐
CARDIOVASCULAR	**NO**	**YES**	**?**	**NEUROLOGICAL**	**NO**	**YES**	**?**
High Blood Pressure	☐	☐	☐	Headaches	☐	☐	☐
High Cholesterol	☐	☐	☐	Migraines	☐	☐	☐
Other:				Seizures	☐	☐	☐
CONSTITUTIONAL	**NO**	**YES**	**?**	**CANCER**	☐	☐	☐
Allergies/Hay Fever	☐	☐	☐	If Yes, Type:			
				If Yes, Treatment:			

Is there anything else you'd like us to know about your health?

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****Family** History**

Please complete the field below for **FAMILY**: **RELATIONSHIP TO YOU:**

DISEASE/CONDITION	**NO**	**YES**	**?**	
Blindness	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment	☐	☐	☐	
Diabetes	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Other:	☐	☐	☐	

______________________ ________

Patient/Guardian Signature *Date*