K. Dean Evans, Jr., O.D.
Medical History Questionnaire

Patient Name_____ Today's Date _____ Male ❑ Female ❑
Mailing Address_____ City_____ St_____ Zip _____
Phone: Primary (___)_____ Cell (___)_____ E-mail_____ Birthdate ___/___/___
Family Dr._____ Phone (___) _____ Date of last medical exam___/___/___
Date of last eye exam ___/___/___ Social Security # _____

RESPONSIBLE PARTY INFORMATION (If patient is a minor or not the primary insurance holder)

Full Name_____ Social Security # _____ Male ❑ Female ❑
Address_____ City_____ St___ Zip_____ Birthdate ___/___/__
Relationship to Patient _____
Vision Insurance_____ Medical Insurance_____
Employer_____ Job Position/Title _____
Whom may we thank for referring you to our office? _____

I AGREE THAT I, THE PATIENT/RESPONSIBLE PARTY WILL BE REQUIRED TO PAY ALL AMOUNTS NOT PAID BY THE INSURANCE COMPANY.
PATIENT/RESPONSIBLE PARTY SIGNATURE_____DATE_____

MEDICAL AND PAST HISTORY

List any medications you take: _____ _____ _____
_____ _____ _____
List all major illnesses and injuries: _____ _____ _____
_____ _____ _____
List any surgeries you have had: _____ _____ _____
_____ _____ _____

Have you had crossed eyes? ❑ Yes ❑ No _____
Have you had lazy eye? ❑ Yes ❑ No _____
Have you had drooping eyelid? ❑ Yes ❑ No _____
Have you worn contact lenses? ❑ Yes ❑ No _____
Do you have allergies to any medications? ❑ Yes ❑ No _____
If yes, please list: _____ _____ _____
_____ _____ _____

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness	❑	❑	_____
Cataract	❑	❑	_____
Glaucoma	❑	❑	_____
Macular degeneration	❑	❑	_____
Retinal detachment	❑	❑	_____
Arthritis	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Heart attacks	❑	❑	_____
High blood pressure	❑	❑	_____
Kidney disease	❑	❑	_____
Lupus	❑	❑	_____
Sjogren's Syndrome	❑	❑	_____
Stroke	❑	❑	_____
Thyroid disease	❑	❑	_____
Tuberculosis	❑	❑	_____
Other	❑	❑	_____

Please turn this form over and complete side 2

SOCIAL HISTORY *(This information is kept strictly confidential. However, you may discuss this portion only with the doctor if you prefer.)*

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Current occupation:_____

Do you drive? ..... ❑ Yes ❑ No

Do you have visual difficulty when driving? ❑ Yes ❑ No

Do you have problems with night vision? ..... ❑ Yes ❑ No

Have you ever tried to wear contacts? ..... ❑ Yes ❑ No

Do you currently wear glasses? ..... ❑ Yes ❑ No

If YES, how long have you had your current pair?_____

Do you drink alcohol? ❑ Yes ❑ No

If YES, how many glasses a day?_____

Do you smoke? ❑ Yes ❑ No

If YES, how many packs a day?_____

Have you ever had a blood transfusion ❑ Yes ❑ No

Have you ever been exposed to HIV or other sexually transmitted disease? ❑ Yes ❑ No

REVIEW OF SYSTEMS

Do **you** currently have any problems in the following areas? If "yes", provide information.

	YES	NO
Constitutional Symptoms		
Fever	❑	❑
Weight loss	❑	❑
Other	❑	❑
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	❑	❑
Occasional tearing	❑	❑
Glare/Light sensitivity	❑	❑
Eye pain or soreness	❑	❑
Chronic infection of eye or lid	❑	❑
Sties, Chalazion	❑	❑
Fluctuating visual acuity	❑	❑
Tired eyes	❑	❑
Psychiatric	❑	❑
Endocrine	❑	❑
Thyroid and other glands	❑	❑
Hematologic/Lymphatic		
Blood	❑	❑
Lymph nodes	❑	❑
Swelling	❑	❑

	YES	NO
Ears, nose, mouth, throat		
Sinus congestion	❑	❑
Runny nose	❑	❑
Postnasal drip	❑	❑
Chronic cough	❑	❑
Dry throat/mouth	❑	❑
Vascular/Cardiovascular		
Diabetes	❑	❑
Heart pain	❑	❑
High Blood pressure	❑	❑
Vascular Disease	❑	❑
Respiratory (lungs/breathing)		
Chronic bronchitis	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Gastrointestinal (stomach/intestines)		
Diarrhea	❑	❑
Constipation	❑	❑
Genitourinary (genitals/kidney/bladder)	❑	❑
Musculoskeletal		
Muscle pain	❑	❑
Joint pain	❑	❑
Rheumatoid Arthritis	❑	❑
Integumentary (skin and/or breast)	❑	❑
Neurological	❑	❑
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Allergic/Immunologic	❑	❑
Head allergy symptoms	❑	❑
Seasonal allergies	❑	❑
Hay fever symptoms	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain and list all medications:

_____

_____

History reviewed. ❑ No changes ❑ Additions as noted above

Physician's signature:_____ Date:_____