

Sacramento Contact Lenses & Optometry, Inc.

Medical History Questionnaire

Name _____ Today's date _____

Spouse's Name _____ Children's Names _____

Address _____ City _____ Zip _____

Home Phone(_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

E-mail _____ Occupation _____ Employer _____

Birth Date _____ Social Security # _____ Date of last eye exam _____

Name of medical Dr. _____ Dr.'s phone # _____

Medical Ins. Co. _____ Insurer's ID # _____

Vision Ins. Co. _____ Insurer's ID # _____

Do You participate in a Flexible or Health spending account? YES NO

Whom may we thank for referring you? _____

Medical History

Do you have any allergies to medications? Please explain _____

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

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

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

Are you pregnant and/ or nursing? No yes

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

Do you wear contact lenses? No yes if yes, how old are your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No yes

Family History

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

Blindness	no	yes	_____
Cataract	no	yes	_____
Crossed eyes	no	yes	_____
Glaucoma	no	yes	_____
Macular Degeneration	no	yes	_____
Retinal Detachment/Disease	no	yes	_____
Arthritis	no	yes	_____
Cancer	no	yes	_____
Diabetes	no	yes	_____
Heart Disease	no	yes	_____
High Blood Pressure	no	yes	_____
Kidney Disease	no	yes	_____
Lupus	no	yes	_____
Thyroid Disease	no	yes	_____
Other _____			_____

Please turn this form over and complete side two

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

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

Do you use tobacco products? No yes If yes, type/ amount/ how long _____
Do you drink alcohol? No yes If yes, type/ amount/ how long _____
Do you use illegal drugs? No yes If yes, type/ amount/ how long _____
Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Constitutional

Fever, Weight loss/ gain no yes

Integumentary (skin) no yes

Neurological

Headaches no yes

Migraines no yes

Seizures no yes

Eyes

Loss of vision no yes

Blurred vision no yes

Distorted vision/halos no yes

Double vision no yes

Dryness no yes

Mucous discharge no yes

Redness no yes

Sandy or gritty feeling no yes

Itching no yes

Burning no yes

Foreign body sensation no yes

Excess tearing/watering no yes

Glare/light sensitivity no yes

Eye pain or soreness no yes

Chronic infection of eye or lid no yes

Sties or chalazion no yes

Flashes/ floaters in vision no yes

Tired eyes no yes

Endocrine

Thyroid/other glands no yes

Allergic/ immunologic no yes

Ears, nose, mouth, throat

Allergies/ hay fever no yes

Sinus congestion no yes

Runny nose no yes

Post-nasal drip no yes

Chronic cough no yes

Dry throat/mouth no yes

Respiratory

Asthma no yes

Chronic bronchitis no yes

Emphysema no yes

Vascular / Cardiovascular

Diabetes no yes

Heart pain no yes

High blood pressure no yes

Vascular disease no yes

Gastrointestinal

Diarrhea no yes

Constipation no yes

Genitourinary

Genitals/ Kidney/ Bladder no yes

Bones/ Joints/ Muscles

Rheumatoid arthritis no yes

Muscle pain no yes

Joint pain no yes

Lymphatic/Hematologic

Anemia no yes

Bleeding problems no yes

Psychiatric

no yes

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

Signature _____ Date _____

Dr's Signature _____ Date _____