

# Sacramento Contact Lenses & Optometry, Inc.

## Medical History Questionnaire

Please print

Name \_\_\_\_\_ Today's date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex M F 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 # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

### 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, 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 is 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:

**Please circle**

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:

	Please circle			Please circle	
<b>Constitutional</b>			<b>Ears, nose, mouth, throat</b>		
Fever, Weight loss/ gain	no	yes	Allergies/ hay fever	no	yes
<b>Integument</b> (skin)	no	yes	Sinus congestion	no	yes
<b>Neurological</b>			Runny nose	no	yes
Headaches	no	yes	Post-nasal drip	no	yes
Migraines	no	yes	Chronic cough	no	yes
Seizures	no	yes	Dry throat/mouth	no	yes
<b>Eyes</b>			<b>Respiratory</b>		
Loss of vision	no	yes	Asthma	no	yes
Blurred vision	no	yes	Chronic bronchitis	no	yes
Distorted vision/halos	no	yes	Emphysema	no	yes
Double vision	no	yes	<b>Vascular / Cardiovascular</b>		
Dryness	no	yes	Diabetes	no	yes
Mucous discharge	no	yes	Heart pain	no	yes
Redness	no	yes	High blood pressure	no	yes
Sandy or gritty feeling	no	yes	Vascular disease	no	yes
Itching	no	yes	<b>Gastrointestinal</b>		
Burning	no	yes	Diarrhea	no	yes
Foreign body sensation	no	yes	Constipation	no	yes
Excess tearing/watering	no	yes	<b>Genitourinary</b>		
Glare/light sensitivity	no	yes	Genitals/ Kidney/ Bladder	no	yes
Eye pain or soreness	no	yes	<b>Bones/ Joints/ Muscles</b>		
Chronic infection of eye or lid	no	yes	Rheumatoid arthritis	no	yes
Sties or chalazion	no	yes	Muscle pain	no	yes
Flashes/ floaters in vision	no	yes	Joint pain	no	yes
Tired eyes	no	yes	<b>Lymphatic/ Hematological</b>		
<b>Endocrine</b>			Anemia	no	yes
Thyroid/other glands	no	yes	bleeding problems	no	yes
<b>Allergic/ immunologic</b>	no	yes	<b>Psychiatric</b>	no	yes

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

---

**Payments due in full at the time services are rendered. I understand that I am responsible for payment on my account. If an insurance authorization is used as payment, I am responsible for the deductibles, overages, non-covered services, and for payment in full should the insurance company deny my eligibility.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr's Signature \_\_\_\_\_ Date \_\_\_\_\_