Medical History Questionnaire ___/___/20__

East Bay Vision Center Optometry

Name (Last, First): _____

Reason(s) for today's visit: _____

Female/Male (circle one)

Vision/Medical insurance: _____

Birth Date: _____/_____/_____ (mm/dd/yy)

Ethnicity (please circle one):
--American Indian or Alaska Native
-- Asian
-- Black or African American
-- Native Hawaiian or Other Pacific Islander
-- White
-- Not Disclosed

Address: _____

_____

Social Security # (last 4 digits): _____

Phone #: _____

Race: Hispanic/Latino or Non-Hispanic/Latino

Email: _____

Preferred Language: _____

Last eye exam: ___/___/___Last physical exam: ___/___/___

Occupation: _____

Height/Weight: _____ /_____

Medical History

Do you have any **allergies** to medication? NO/YES, If yes, list and ***explain allergy reaction***:_____

_____

List any medications you take :_____

_____

List all major injuries, surgeries and/or hospitalization you had: _____

Are you pregnant and/or nursing: NO/YES

Do you wear glasses: NO/YES
Do you wear contact lenses: NO/YES
Type of contact lenses: Rigid/soft/extended wear/others Are they comfortable: NO/YES Solution used: _____

Personal and Family History

Disease/Condition	No	Yes	?	Relationship (Self/Parent/Sibling)
Blindness 失明	____	____	____	_____
Cataract 白內障	____	____	____	_____
Crossed eyes 鬥雞眼	____	____	____	_____
Glaucoma 青光眼	____	____	____	_____
Macular degeneration 黃斑	____	____	____	_____
Retinal detachment視網膜脫離	____	____	____	_____
Arthritis關節炎	____	____	____	_____
Cancer癌症	____	____	____	_____
Diabetes糖尿病	____	____	____	_____
Heart disease心臟疾病	____	____	____	_____
High blood pressure高血壓	____	____	____	_____
Kidney disease腎臟疾病	____	____	____	_____
Thyroid disease**甲狀腺**	____	____	____	_____

Other_____

****Please turn this form over and complete side two****

Social History *this information is kept strictly **confidential. However, you may discuss this portion with your doctor if you prefer.***

❑ Yes, I would prefer to discuss my Social History directly with my doctor

Do you drive? NO/YES If yes, do you have any visual difficulty when driving? NO/YES If yes, please describe: ____

_____

Do you smoke/吸烟? NO/YES If yes, type/amount/how long:_____

Do you drink alcohol? NO/YES If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: NO/YES, Gonorrhea/Hepatitis/HIV/Syphilis

Review of Systems

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

❑ **All normal**

	No	Yes	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	___	___	___
INTEGUMENTARY (SKIN)	___	___	___
NEUROLOGICAL			
Headaches/頭痛	___	___	___
Migraine/偏頭痛	___	___	___
Seizure/癲癇	___	___	___
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	___	___	___
Glare/Light Sensitivity	___	___	___
Eye Pain or Soreness	___	___	___
Stye or Chalazion	___	___	___
Flashes in Vision	___	___	___
Floaters in Vision	___	___	___
Tired Eyes	___	___	___
ENDOCRINE			
Thyroid/Other Glands/甲状腺	___	___	___
PSYCHIATRIC	___	___	___

	No	Yes	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay fever	___	___	___
Sinus Congestion	___	___	___
Runny Nose	___	___	___
Chronic Cough	___	___	___
Dry Throat / Mouth	___	___	___
RESPIRATORY			
Asthma/哮喘	___	___	___
Bronchitis	___	___	___
Emphysema	___	___	___
VASCULAR/CARDIOVASCULAR			
Diabetes/糖尿病	___	___	___
High Blood Pressure/高血壓	___	___	___
High Cholesterol高膽固醇	___	___	___
Vascular Disease/中風/心臟病	___	___	___
GASTROINTESTINAL			
Diarrhea	___	___	___
Constipation	___	___	___
GENITOURINARY			
Genitals/Kidney/Bladder	___	___	___
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis/關節炎	___	___	___
Muscle Pain	___	___	___
Joint Pain	___	___	___
HEMATOLOGIC/LYMPHATIC			
Anemia	___	___	___
Bleeding Problems	___	___	___
ALLERGIC / IMMUNOLOGIC	___	___	___

If you answered YES to any of the above boxes or have a condition not listed, please explain:_____

_____

Patient Information: Dilation eye drops are used to evaluate ocular health as a part of comprehensive eye exam. Please let your doctor know if you are unable to be dilated and circle YES here: **Permission to dilate after education: NO/YES**

Patient's Signature: X_____ "I certify that the information I provided is true and that I understand that I am responsible for payment if my insurance has declined payment for any of the services I received."

Doctor's Signature: X_____