Medical History Questionnaire

Dr./Mr./Mrs./Ms/Miss ____Today's Date:____/_____/_____

Address____City__________Zip Code________________

Phone: Home: _____________________Work: __________________Cell_______________________

E-Mail____Age__________Date of Birth ____/_____/_____

Spouse's Name_______________Parent's Name (if under 18)____________Referred by ______ _____

In case of emergency, please contact_____________________________Phone____________________

Employer______________________ **Occupation**_______________**Vision Insurance**_____________

Medical History

Last Medical Exam____/____/____ Medical Doctor: _____________________________

List all major **injuries, surgeries** and/or **hospitalizations** you have had__________________________

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Do you have **allergies** to Medications? □ No If Yes, which ones?__________________________
List any **Medications** you take (i.e. oral contraceptives, aspirin, over the counter medications & herbs)

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Eye History Last Eye Exam ____/____/______

Have you had any **eye conditions** such as: crossed eyes, lazy eye, glaucoma, retinal disease, cataracts, styes, eye infections or eye injury?____
Do you wear **glasses**? □ No If Yes, how old are your glasses?____________________
Do you wear **contact lenses**? □ No If Yes, how old is your CL prescription? _________________
How many hours do you spend on the **computer** each day?________________
What **hobbies** & **sports** activities do you participate in?_____________________________________

Family History
Do you have a family member with any of the following conditions? Please ***Circle***.

Disease	*Relationship to you (parents, grandparents, siblings, children)*
Blindness	
Cataract	
Crossed Eyes	
Glaucoma	
Macular Degeneration	
Retinal Detachment/Disease	
Arthritis	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Lupus	
Thyroid Disease	
Sarcoid	
Other	

More on Back ------>

BERKELEY OPTOMETRIC GROUP, Drs. Chun, Fujikawa, Hom & Shintani
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Social History

(*This information is kept strictly confidential; however, you may discuss this with the doctor privately if you wish)*

Do you **drive**? ☐ No ☐ Yes If yes, do you have difficulty seeing when driving? ☐ No ☐ Yes

Do you **smoke**? ☐ No ☐ Yes If yes, type/amount per week: ___________________________

Do you drink **alcohol**? ☐ No ☐ Yes If yes, type/amount per week:______________________________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Herpes

Review of Systems

Do you currently, or have you ever had any problems in the following areas? Please ***circle*** the condition(s) that you have or have had.

SYSTEM	System
Constitutional	**Ears, Nose, Mouth, Throat**
Fever, weight loss/gain	Allergies/Hay Fever
Skin Disorders	Runny Nose/Sinus
Neurological	Chronic cough
Headaches	**Respiratory**
Seizures	Asthma
Eyes	Chronic Bronchitis
Blurred/Distorted vision	Emphysema
Glare/light sensitivity	**Vascular / Cardiovascular**
Loss of side vision	High blood pressure
Double vision	Diabetes
Dryness	Heart disease
Mucous discharge	**Gastrointestinal**
Redness	Diarrhea/Constipation
Excess tearing / watering	**Genitourinary**
Itching/Burning/Sandy	Kidney/Bladder infect
Flashes/floaters in vision	**Bones / Joints / Muscles**
Eye pain or soreness	Rheumatoid Arthritis
Endocrine	Muscle pain
Thyroid / other glands	**Lymphatic / Hematological**
Allergic / Immunologic	Anemia
Psychiatric	Bleeding problems
Other__________________________________	

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For office use only:

Reviewed by Patient and changes as indicated:

Patient's signature: ______________________________________ Date: _________________________

Patient's signature: ______________________________________ Date: _________________________

Patient's signature: ______________________________________ Date: _________________________

Patient's signature: ______________________________________ Date: _________________________

Patient's signature: ______________________________________ Date: _________________________

Patient's signature: ______________________________________ Date: _________________________