***Medical History Questionnaire*** *Dr.'s Elaina M. Groo & John Kaknis*

*06/21*

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| Last First Today’sName Name Date Date of Birth Date of Last Eye Exam Eye Doctor Date of Last Physical Exam PhysicianMedical History: Height:\_\_\_\_\_\_Weight: **LIST** **MEDICATIONS you are take (prescription and/or over the counter)**Do you have any allergies or allergies to any medications? Yes NO If yes, list the medications:List all major illnesses (high blood pressure, diabetes, heart attack, glaucoma, etc.) or injuries (concussion, etc.):List any surgeries and/or hospitalizations you have had ( ie. tonsillectomy, appendectomy, cataract) A re you pregnant and or nursing? Yes [ ] NO [ ]Do you wear glasses? Yes [ ] NO [ ] If yes, how old is your present pair of lenses? Do you wear contact lenses? Yes [ ] NO [ ] If yes, how old is your present pair of lenses? Type of contact lenses? [ ] Rigid [ ] Soft [ ] Extended Wear [ ] Other Are they comfortable? [ ] Yes [ ] NOWhat type of disinfection system do you use?**Review of Systems** Do you currently have any problems in the following areas? If yes, please provide information**SYMPTOMS below require a medical visit and will be billed to your medical coverage. Evaluation and treatment are not routine and are NOT covered with your vision benefit. Additional appointments may be necessary.**YES NO |
|  |  |  |  |
| Loss of Vision |  |  |  |
| Blurred vision |  |  |  |
| Fluctuating 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 |  |  |  |
| Infection of eye or lid (stye) |  |  |  |
| Tired eyes |  |  |  |
| Crossed eyes, lazy eye |  |  |  |
| Drooping Eyelid |  |  |  |
| Flashes/Floaters |  |  |  |
| Other |  |  |  |
|  |  |  |  |

Please continue on back

**Review of Systems *(continued)***

**EARS, NOSE MOUTH, THROAT**

Allergies/ Hay Fever Sinus congestion Runny Nose

Post-Nasal Dip Chronic Cough Dry Throat/ Mouth

**RESPIRATORY**

Asthma

Chronic Bronchitis Emphysema

**VASCULAR / CARDIOVASCULAR**

Diabetes Heart Pain

High Blood Pressure Vascular Disease

**GASTROINTESTINAL**

Diarrhea Constipation

**GENITOURINARY**

Genitals / Kidney / Bladder

**BONES / JOINTS / MUSCLES**

Rheumatoid Arthritis Muscle Pain

Joint Pain

**LYMPHATIC / HEMATOLOGIC**

Anemia

Bleeding Problems **ALLERGIC/ IMMUNOLOGIC PSYCHIATRIC**

NO YES

**Explain**

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| **Family History** (note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:NO YES RelationshipBlindness [ ] [ ] Cataract [ ] [ ] |
| Crossed Eyes | [ | ] | [ | ] |  |
| Macular Degeneration | [ | ] | [ | ] |  |
|  |
| Retinal Detachment DiseaseArthritis Cancer Diabetes Heart DiseaseHigh Blood Pressure Kidney Disease Lupus/AutoimmuneThyroid Disease Other  | [[[[[[[[[[[ | ]]]]]]]]]]] | [[[[[[[[[[[ | ]]]]]]]]]]] |
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If you answered YES to any of the above or have a condition not listed, please explain & list additional medication :

**Social History *T****his information is kept confidential. However, you may discuss this portion directly with the doctor if you prefer.* [ ] Yes, I would prefer to discuss my Social History information directly with my doctor. (check box)

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

Current occupation / School / Grade ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: [ ] single, [ ] married, [ ] widowed, [ ] divorce

Living arrangements: *(asked to determine if assistance is needed for the visually disabled)*

Doctor Date



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| *Dear Patient: This questionnaire was created to assist us in helping you choose the eyewear best suited to your particular needs and lifestyle concerns. Please take a moment to answer all the questions that apply to you.**Thank you for taking the time to complete this form.* |
| **1. What do you like about your current pair of glasses and or contact lenses?** |
| **2. What don't you like about your current pair of glasses and or contact lenses?** |
| **3. Your activities: ( circle all that apply)**cooking sewing needlepoint/knitting board games sofciering/welding painting woodworking electrical golf skiing/skating/snow boarding snorkling/suba/swim auto repair plumbing use of power toolspainting musical instrument art scrapebookjcrafts cards/bingo woodworking fishing boating gardening/landscaping |
| **4. Are you bothered by glare from any of the following?** ( **circle all that apply)**night driving/headlights haze flourscent lights smart phone sunshine/uv exposure computer screens other tablets |
| **5. Does your work entail unusual visual demands due to any of the following: ( cir, le all that apply)**distance viewing outdoor work natural or artifical lighting caustic environent near viewing indoor work abrupt changes in light levels clean room position driving microscope/ telescope other |
| **6. What electronic devices do you use: smart phone, tablet, kindel, video games and how much time on each device. Do your eyes tire after viewing/reading/using these devices?** |
|  |
| **7. Do you currently use more than one pair of glasses?**bifocals distance golftrifocals reading tennismultifocals intermediate shootingoccupational computer hunting other hobby: sunglasses | **NO** | **YES (circle all that apply below)**scuba specs swim goggles ski goggles drivingprotective eyewear |  |
| **8. Do you see clearly with the glasses for all the tasks which you need to complete? YES NO if NO ... please explain** |
| **9. Do you use a computer? NO YES What is the distance from the screen to your eyes? inches? Lap top, distance inches** |
| **Is the screen positioned to your Right Left Center?****computer a day?**  |  | **How many hours do you spend at the** | ' |
| **10. Do you currently wear contact lenses? NO YES What type of lens? (soft/disposable/gas perme- able/bifocal etc.)****What disinfection system do you use?****How many hours a day do you wear your contact lenses? Disinfection System:** Please list all the family members living at homeName Last Eye Exam Date of Birth |