MEDICAL HISTORY QUESTIONNAIRE

FORSTER EYE CARE, P.C.

Name: _____ Today's Date: _____/ _____/ _____ Race: _____ Sex: ____
Address: _____ Phone:_____ Email: _____
_____ Work Phone: _____
Place of employment: _____ Occupation: _____
Birth Date: _____/ _____/ _____ Social Security #: _____/ _____/ _____ Marital Status: M S D W
►Name you prefer to be called (if different from above):_____ Spouse's name: _____
►Date of last eye exam: _____ By Dr. : _____ Age of current glasses: _____
►Name of Primary Physician: _____ Date of last Medical Exam: _____
►Have you ever been examined by Dr. Forster before? □ Yes □ No
►How did you choose our office? (Circle all that apply) *Yellow Pages Family Insurance Internet Location Friend/Co-worker*
►Person to contact in case of emergency: _____ Phone #: _____
* Do you have any allergies to medications? □ Yes □ No If yes, explain: _____
_____
*List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____
_____
_____
_____
*List all major surgeries and/or hospitalizations you have had: _____
_____

*Circle any of the following that you have had: *crossed eyes lazy eye drooping eyelid glaucoma retinal disease cataracts eye infections eye surgery eye injury*
► Are 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 □ No
►Are you interested in Corrective Eye Surgery? □ Yes □ No

FAMILY HISTORY

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

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Color Blindness	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other _____	☐	☐	_____

Please turn this form over and complete side two*

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Please complete **all** information as accurately as possible. Please **print**.

SOCIAL HISTORY

This information is kept strictly 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? ☐ yes ☐ no If yes, type/amount/how long: _____

Do you drink alcohol? ☐ yes ☐ no If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long: _____

Have you 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?

SYSTEM:	YES	NO
CONSTITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching/Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing	☐	☐
Glare/Light Sensitivity	☐	☐
Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Color Blindness	☐	☐
Cataracts	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

SYSTEM:	YES	NO
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Stroke	☐	☐
High Cholesterol	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

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

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____