BLUEGRASS FAMILY VISION
Medical History Questionnaire

Name: _____Name you want to be called:_____
(Mr. Mrs. Miss Dr.)
Address: _____City:_____Zip:_____
Home Phone: _____Cell Phone: _____Work:_____
Preferred # to call: Home ( ) Cell ( ) or work ( ) SS#: _____
Male ( ) Female ( ) Date of Birth: _____/_____/_____ Married ( ) Single ( ) Other ( )
Preferred Language: _____Race: _____Ethnicity:_____
Employer: _____Address:_____
_____Position:_____
Email Address: _____
Insurance:_____ Insured:_____
Insured's D.O.B:_____ Insured's SS#_____

Family Doctor: _____ Last Medical Exam? _____
How long ago was your last eye exam? _____ Where? _____

Do you have any medical allergies? No ( ) Yes ( ) If yes explain: _____
List any medications you take (including oral contraceptives, aspirin, over the counter meds
And home remedies):_____
_____
List all major surgeries and/or hospitalizations you have had: _____
_____
Circle any of the following you have or have had: Lazy Eye Drooping Eyelid Glaucoma
Crossed Eyes Retinal Disease Cataracts Eye Infections Eye Injury
Women: 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 contacts? No ( ) Yes ( ) If yes, how old is your present pair of lenses? _____
What type of contact lenses do you wear? Soft ( ) Extended Wear ( ) Rigid ( ) Other ( )
Are your current contacts comfortable? No ( ) Yes ( )
Social History:
Do you drive? No ( ) Yes ( ) If so, do you have visual difficulty when driving? No ( ) Yes ( )
If yes, 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: _____
Ever been exposed to or infected with: HIV, Hepatitis, Gonorrhea, or Syphilis? No ( ) Yes ( )

PLEASE TURN OVER AND COMPLETE SIDE TWO

Family History

Please note any family history (parents, grandparents, sibling, & children, living or deceased) for the following conditions.

DISEASE/CONDITION	RELATIONSHIP TO YOU	DESEASE/CONDITION	RELATIONSHIP TO YOU
Blindness	_____	Cataracts	_____
Crossed Eyes	_____	Glaucoma	_____
Macular Degeneration	_____	Retinal Detachment	_____
Arthritis	_____	Cancer	_____
Diabetics	_____	Heart Disease	_____
High Blood Pressure	_____	Kidney Disease	_____
Lupus	_____	Thyroid Disease	_____
Other	_____	Other	_____

REVIEW OF SYSTEMS

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
INTEGUMENTARY (Skin)			
Fever, Weight Lose/Gain	☐	☐	☐
NEUROLOGIAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucus Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Sinus Congestion	☐	☐	☐
Allergies/Hay Fever	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drop	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
Heart Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTRONINTESTINAL			
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:

_____

_____

_____

_____ _____

Patient's Signature Date