MOUNTAIN VIEW EYE CARE
Chris Deitrick, O.D., P. A. Emily Smith, O.D.

Medical History Questionnaire

Name:______________________________Today's Date:____________________

DOB:__________Last Eye Exam:_____________Last Medical Exam:______________

Family Physician:__________________________Dr.'s Phone #__________________

How did you hear about us? ❑referred by Dr. ❑website/Google ❑social media ❑referred directly

Pharmacy:______________________________

Medical History

Do you take any medications? ❑ No ❑ Yes If yes, list below. Please include oral contraceptives, over the counter medications, aspirin, and supplements. ***If you have a medication list, please give it to the front desk to make a copy instead of writing everything out.***

____

____

Do you have any allergies to medications? ❑ No ❑ Yes If yes, please explain:

____

____

Have you had any changes in medication since your last visit? ❑ No ❑ Yes

List all major injuries, surgeries, and hospitalizations:

____

____

Review of Systems: ***Do you currently, or have you ever, had problems in the following areas:***

General Symptoms
- Fever ☐
- Weight Loss ☐
- Weight Gain ☐

Eyes
- Loss of Vision ☐
- Blurred Vision ☐
- Distorted Vision ☐ (halos)
- Loss of SIDE vision ☐
- Double vision ☐
- Dryness ☐
- Stye, chalazion ☐
- Discharge ☐
- Redness ☐
- Sandy/gritty feeling ☐
- Tired eyes ☐
- Itching/burning ☐
- Foreign body sensation ☐
- Excess tearing ☐
- Glare/Light sensitivity ☐
- Fluctuating vision ☐
- Eye pain or soreness ☐
- Chronic infection ☐

Hematologic
- Anemia ☐
- Bleeding Problems ☐

Endocrine
- Thyroid ☐
- Diabetes ☐

Allergic/Immunologic
- Seasonal Allergies ☐
- Hay fever ☐
- Dry throat/mouth ☐
- Sinus Congestion ☐
- Runny Nose ☐
- Post nasal drip ☐
- Chronic cough ☐
- Lupus ☐

Cardiovascular
- High Blood Pressure ☐
- Vascular Disease ☐

Respiratory
- Asthma ☐
- Chronic bronchitis ☐
- Emphysema ☐

Gastrointestinal
- Diarrhea/Constipation ☐

Musculoskeletal
- Muscle/Joint Pain ☐
- Rheumatoid Arthritis ☐

Integumentary
- Skin problems ☐

Neurological
- Headaches/Migraines ☐
- Seizures ☐

Genitourinary
- Kidneys/Bladder ☐

Psychiatric ☐

If you need to provide details or have a condition not listed, please list below:

____

____

Please Fill out Front and Back

Check any of the following you have had: ☐dry eye syndrome ☐cataract ☐glaucoma ☐crossed eye ☐floaters ☐retinal disease/detachment ☐macular degeneration ☐eye injury ☐eye surgery

Are you pregnant or nursing? ☐yes ☐no

Do you wear glasses? ☐yes ☐no If yes, how old is your present pair?____________________

Do you wear contacts? ☐yes ☐no If yes, how old is your present pair?____________________

Type of contact lenses? ☐soft ☐rigid Are they comfortable? ☐yes ☐no

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.

Does your vision limit any activities of daily life (driving, reading, sports, work, etc)? ☐No ☐Yes

If yes, please explain:____________________

Do you use tobacco products? ☐No ☐Yes If yes, type/amount/how long:____________________

Do you consume 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 had a blood transfusion? ☐No ☐Yes

Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐None

Family History: ***Please notate parents, grandparents, sibling, or children for the following conditions. DO NOT INCLUDE SPOUSE.***

Disease/Condition	No	Yes	Relationship to you	Disease/Condition	No	Yes	Relationship to you
Blindness	☐	☐	____________	Cancer	☐	☐	____________
Cataract	☐	☐	____________	Diabetes	☐	☐	____________
Crossed Eyes	☐	☐	____________	Heart Disease	☐	☐	____________
Glaucoma	☐	☐	____________	High Blood Pressure	☐	☐	____________
Arthritis	☐	☐	____________	Thyroid Disease	☐	☐	____________
Macular Degeneration	☐	☐	____________	Autoimmune	☐	☐	____________
Retinal Disease	☐	☐	____________	Other		☐	____________

Patient Signature:______________________________ Date:____________________

FOR OFFICE USE ONLY

Doctor Signature:______________________________ Date:____________________

Medical Hx Reviewed Date__________ Dr. Initial_____ Medical Hx Reviewed Date__________ Dr. Initial_____

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