Mountain View Eye Care
Chris Deitrick, O.D., P.A. Emily Smith, O.D. Date:___________________

Medical History Questionnaire

Name:____ DOB:_______________________

Last Eye Exam:__________ Last Medical Exam:_________ Family Physician:____________

Pharmacy:________________ How did you hear about us? _____________________

Please list all current medications (including 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.***

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List any allergies to medications:____________________________________ ☐ None

List all major injuries, surgeries, and hospitalizations:

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

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

Endocrine
- ☐ Diabetes
- ☐ Thyroid

Cardiovascular
- ☐ High Blood Pressure
- ☐ Vascular disease

Hematologic
- ☐ Anemia
- ☐ Bleeding problems

Neurological
- ☐ Headaches/ migraines
- ☐ Seizures
- ☐ Multiple Sclerosis (MS)

Autoimmune
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjofrens

Allergic
- ☐ Seasonal Allergies
- ☐ Dry throat/ mouth
- ☐ Sinus Congestion
- ☐ Chronic cough

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema

Dermatologic
- ☐ Skin problems

Genitourinary
- ☐ Kidney/ bladder

Psychiatric
- ☐ Anxiety

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

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Please fill out the front and back.