Medical History Questionnaire

Dr. Kenneth E. Hooton

Name_____ Date_____

Name of your medical doctor_____

Name of previous eye doctor_____ Time since last eye exam_____

Medical History

List all medications you are taking (including birth control, aspirin, and non prescription medications):

_____

_____

_____

List major injuries, surgeries, and/or hospitalizations you have had:

_____

_____

_____

Do you have any of the following:

_____ Diabetes
_____ Crossed eyes, lazy eye, or double vision
_____ Glaucoma
_____ Eye injury
_____ Loss of side vision
_____ Dryness or sandy/gritty sensation
_____ Itching or burning of eyes
_____ Excess tearing or watering
_____ Eye pain
_____ Unusual sensitivity to light
_____ Any other serious eye problem

_____ Do you have allergies to any medication? If yes, list them:

_____ Are you pregnant or nursing?
_____ Do you use a computer? How many hours/day? _____
_____ Do you wear Contact Lenses, or are you interested in Contacts?
_____ Are you interested in Refractive surgery (such as LASIK)?

For School Children Under Age 19:

Were there any complications in the prenatal, birth, or postnatal time period?
Is the child's physical and mental development normal?
Is the child's school performance satisfactory?

-- Please turn this form over and complete side two --

Social History *(This information is kept strictly confidential. If you wish to speak directly to the doctor, please check here_____)* Check all that apply to you:

_____ Do you drive?
_____ Do you use tobacco? ____ Alcohol? ____ Illegal Drugs?
_____ Have you ever been infected with gonorrhea or syphilis? ____ HIV? ____ Chlamydia?
_____ Have you ever been infected with Hepatitis?
_____ Do you have discomfort being around people?
_____ Have you suffered any physical or mental abuse?
List any persons you wish to allow the doctor to talk to about your vision:

Family History
Have any blood relatives (parents, grandparents, siblings, children) had any of the following: Relationship to you:

_____ Blindness _____
_____ Crossed or Lazy Eyes _____
_____ Glaucoma _____
_____ Macular Degeneration _____
_____ Retinal Detachment _____
_____ Significant Arthritis _____
_____ Diabetes _____
_____ Heart Disease _____
_____ High Blood Pressure _____
_____ Other Serious Eye Disease _____

Review of Systems
Mark if you have problems with any of these systems:

_____ Constitutional (e.g. fever, weight gain or loss)
_____ Integumentary (skin)
_____ Neurological (e.g. headaches, seizures)
_____ Endocrine (e.g. thyroid, diabetes)
_____ Ears,Nose,Mouth,Throat
_____ Respiratory (lungs)
_____ Vascular/Cardiovascular (e.g. heart, hypertension)
_____ Gastrointestinal
_____ Genitourinary
_____ Bones/Joints/Muscles (e.g. arthritis)
_____ Lymphatic/Hematologic
_____ Allergic/Immunologic
_____ Psychiatric

If you checked any of the above, please list the problem(s):

Patient's Signature_____ Doctor's Signature_____/__/__