Welcome to DiNapoli Opticians

Medical History Questionnaire

Last Name: _____ First Name: _____ Middle Initial:___ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

SSN _____ Home Phone _____Cell Phone _____ Work Phone _____

Occupation _____ Employer _____

E-mail (home_____ E-mail (work) _____

Primary Care Doctor _____ Date of last exam _____

Primary Eye Doctor _____ Date of last **Eye** Exam _____

Emergency Contact Person _____ Phone _____ Relationship _____

Were you referred to this office?____ Yes ____ No By Whom? _____

List **medications** you are currently taking (prescriptions, over-the-counter, aspirin, vitamins and herbals etc.)

_____ _____ _____

Do you have any **allergies** to any medications? ____ **Yes** ____ **No**

If so please list **medications** and **reaction**: _____

Do you ever suffer from red eyes, itchy eyes, watery eyes or swollen eye lids? **____Yes _____No**

Do you ever use over-the-counter eye drops (i.e. Visine, Visine AC, Opcon-A, etc.) to treat red eyes, itchy eyes, watery eyes or swollen eye lids? **_____Yes ____No**

List all **major illnesses**, (high blood pressure, heart attack, cancer, etc.) or **injuries** (abrasion, contusion, etc.)

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, cardiovascular, etc.)_____

_____

REVIEW OF SYSTEMS Please check **Yes** or **No** in **all** boxes below:

EYES

Do you **currently** have any problems in the following areas? If **yes** please provide explanation.

Problem	YES	NO	Explanation of Problem
Loss of vision			
Blurred vision			
Fluctuating vision			
Double vision			
Cataracts			
Macular Degeneration			
Glaucoma			
Dryness			
Sandy or gritty feeling			
Mucous discharge			
Floaters			
Redness			
Itching			
Burning			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or eyelid (blepharitis, stye, etc.)			
Headaches			
Other			

NEXT PAGE PLEASE

Please check **Yes** or **No** in **all** boxes below:

PERSONAL HEALTH HISTORY

CONDITION	YES	NO
EARS, NOSE, THROAT (sinus, ear infection, chronic cough, etc.)		
CARDIOVASCULAR (heart, vessels, etc.)		
RESPIRATORY (asthma, emphysema, bronchitis, etc.)		
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)		
GENITOURINARY (kidneys, bladder, etc.)		
MUSCLES, BONES, JOINTS (arthritis, etc.)		
SKIN (acne, dermatitis, psoriasis, skin cancer, etc.)		
NEUROLOGICAL (multiple sclerosis, stroke, etc.)		
PSYCHOLOGICAL (anxiety, depression, insomnia, etc.)		
ENDOCRINE (diabetes, thyroid, etc.)		
BLOOD/LYMPH (anemia, cholesterolemia, etc.)		
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, Sjogrens, etc.)		
Other (fevers, weight loss, etc.)		

FAMILY HEALTH HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Cataracts			
BLINDNESS			
GLAUCOMA			
MACULAR DEGENERATION			
RETINAL DETATCHMENT			
DIABETES			
THYROID DISEASE			
HEART DISEASE			
HIGH BLOOD PRESSURE			
STROKE			
ARTHRITIS			
CANCER (list type)			
Other			

SOCIAL HISTORY (circle one)

Do you drive **Y N**

Do you have visual difficulty when driving? **Y N**

Do you wear glasses? **Y N** If YES, how long have you had the current prescription? _____

Do you currently wear contact lenses? **Y N** If YES, what kind? _____

If YES, how long have you worn contact lenses? _____

Have you ever tried to wear contact lenses? **Y N**

Do you smoke? **Y N** If YES: ____occasional ____½ pack/day ____1 pack/day ____ 1+ pack/day

Do you drink alcohol? **Y N** If YES: ____occasional ____1 per day ____ 2-3/day ____ 4+/day

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Office Use Only: History reviewed: No Changes _____ Additions as noted above _____

Optometrist's Signature _____ TM AW MH RS date: ____/_____/_____