Almaden Family Optometric Center

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name (Last, First):___________________________

Birth Date (mm/dd/yyyy):____________________________

Gender: **Female / Male**

Cell/Text Phone #:__________________________________

Email:____

Occupation:____________________________________

Hobbies:_______________________________________

Computer/phone usage (# hr/day): ________________

Purpose of today's visit__________________________

Last eye exam (mm/yyyy):_______________________

Personal Medical History *please check the box if you have this condition

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ **Asthma**
- ☐ COVID-19
- ☐ Cerebrovascular disease
- ☐ Lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depression
- ☐ **Diabetes (type 1 or 2)**
- ☐ **Elevated blood pressure**
- ☐ Renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflex
- ☐ **History of** high blood pressure
- ☐ **High cholesterol**
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Tumor________________
- ☐ Cancer________________
- ☐ Radiation treatment
- ☐ Other:________________

List any past surgeries and dates: ____

Personal Ocular History *please check the box if you have this condition

- ☐ None
- ☐ Allergic conjunctivitis
- ☐ Blepharitis
- ☐ Cataract right eye
- ☐ Cataract left eye
- ☐ Contact lenses usage (type:_______)
- ☐ Degeneration of macula right eye
- ☐ Degeneration of macula left eye
- ☐ Dry eyes
- ☐ Elevated eye pressure right eye
- ☐ Elevated eye pressure left eye
- ☐ Epiretinal membrane right eye
- ☐ Epiretinal membrane left eye
- ☐ Eye strain
- ☐ Glaucoma right eye
- ☐ Glaucoma left eye
- ☐ Itchy eye
- ☐ History of retinal detachment repair
- ☐ Ocular migraine
- ☐ Posterior vitreous detachment right eye
- ☐ Posterior vitreous detachment left eye
- ☐ Retinal tear right eye
- ☐ Retinal tear left eye
- ☐ Retinopathy due to diabetes
- ☐ Strabismus
- ☐ Floater right eye
- ☐ Floater left eye
- ☐ Wears glasses
- ☐ Other:_____________________________

List any past eye surgeries or injuries and dates:____

List any **medication**s you take:____

List any **allergies** you have including drug allergies:

____

- ☐ No Known Drug Allergy

Social History (circle one)

Do you smoke tobacco? YES / NO

Do you consume alcohol? YES / NO

Are you currently pregnant? YES / NO

Do you drive? YES / NO

Review of System *please check the box if you CURRENTLY have this condition

- ☐ None
- ☐ Fever
- ☐ High blood pressure
- ☐ Depression
- ☐ Joint pains
- ☐ Shortness of breath
- ☐ Distorted vision
- ☐ Loss of vision
- ☐ Rash/skin
- ☐ Arthritis
- ☐ Cough
- ☐ Thyroid abnormalities
- ☐ Anxiety
- ☐ Eye pain
- ☐ Dry mouth
- ☐ Diarrhea
- ☐ Headache
- ☐ Allergies
- ☐ Anemia
- ☐ Stroke
- ☐ Blurry vision
- ☐ Redness in eyes
- ☐ Tearing/watery eyes
- ☐ Diabetes
- ☐ Stuffy nose
- ☐ Constipation
- ☐ Bleeding
- ☐ Seeing flashes of light (not related to headache or environment)
- ☐ Black out of vision
- ☐ Pregnancy or planning a pregnancy
- ☐ Other:__________________________

Family History *please check the box if anyone in your family has this condition AND list the relationship (mother, father, sibling, grandmother, grandfather, etc.)

- ☐ None
- ☐ Blindness ___________________________________
- ☐ High myopia ≥ - 6.00___________________________
- ☐ Strabismus (eye turn)__________________________
- ☐ Glaucoma____________________________________
- ☐ Macular degeneration__________________________
- ☐ Retinal detachment_______________________
- ☐ Cancer___________________________________
- ☐ Diabetes_________________________________
- ☐ High blood pressure______________________
- ☐ High cholesterol__________________________
- ☐ Other:____________________________________

Dilation and Retinal Photographs Consent

Dilation and retinal photographs (fundus photograph or optomap retinal scan) are done as part of a comprehensive eye examination to evaluate the health of your eyes. While retinal photographs do not replace dilation, they provide critical details to help doctors to see the back of your eyes better. Please see dilation waiver form for details on *the importance and the side effects of dilation drops (blur, sensitivity to light, etc).*

- ☐ ***I give the office permission to dilate my eyes with doctor's recommendation or***
- ☐ ***I decline dilation***
- ☐ ***Permission for retinal photograph with a $39 copay***

Axial Length Measurement Consent

MYAH measures the precise length of your eyeball with interferometry without eye drops, ultrasound or x-ray. This test helps our doctors to better manage and track your nearsightedness prescription as eyeball elongation is highly correlated with nearsightedness progression. An eyeball length > 26mm is a risk factor of ocular complications such as retinal detachment. This makes it important for patients to get their eyeball length measured at the annual eye exam.

- ☐ ***Permission for axial length measurement with a $20 fee***

By signing below, I certify that the information I provided is true and that I understand that I am responsible for payment if my insurance has declined reimbursements for any services rendered.

Patient or Guardian's Signature: _________________________________ Date: _______________________

Doctor's Signature: ____ Date: _______________________