

Medical History Questionnaire ____/____/201__

Almaden Family Optometric Center

Name (Last, First): _____

Female/Male (circle one)

Birth Date: ____/____/____ (mm/dd/yy)

Address: _____

Phone #: _____

Alternate. Phone #: _____

Email: _____

Reason(s) for today's visit: _____

Last eye exam: ____/____/____ Last physical exam: ____/____/____

Primary Insured's Name (Last, First): _____

Primary Insured's Birth Date: ____/____/____ (mm/dd/yy)

Primary Insured's Social Security # (last 4 digits): _____

Vision/Optical Insurance: _____

Medical Insurance: _____

Preferred Language: _____

Occupation: _____

Hobbies: _____

Whom may we thank for your referral: _____

Medical History

Do you have any **allergies** to medication 藥物過敏? NO/YES, If yes, list and **explain allergy reaction:** _____

List any medications 藥物 you take: _____

List all major injuries, surgeries and/or hospitalization you had: _____

Are you pregnant and/or nursing: NO/YES

Do you wear glasses: NO/YES

Do you wear contact lenses: NO/YES

Type of contact lenses: Rigid/soft/extended wear/others

Are they comfortable: NO/YES

Solution used: _____

Personal and Family History

Disease/Condition	No	Yes	?	Relationship (Self/Parent/Sibling)
Blindness 失明	_____	_____	_____	_____
Cataract 白內障	_____	_____	_____	_____
Crossed eyes 鬥雞眼	_____	_____	_____	_____
Amblyopia (Lazy eye) 弱視	_____	_____	_____	_____
Glaucoma 青光眼	_____	_____	_____	_____
Macular degeneration 黃斑	_____	_____	_____	_____
Retinal detachment 視網膜脫離	_____	_____	_____	_____
Arthritis 關節炎	_____	_____	_____	_____
Cancer 癌症	_____	_____	_____	_____
Diabetes 糖尿病	_____	_____	_____	_____
Heart disease 心臟疾病	_____	_____	_____	_____
High blood pressure 高血壓	_____	_____	_____	_____
Kidney disease 腎臟疾病	_____	_____	_____	_____
Lupus 狼瘡病	_____	_____	_____	_____
Thyroid disease 甲状腺	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Please turn this form over and complete side two

Social History *this information is kept strictly confidential. However, you may discuss this portion with your doctor if you prefer.*

Yes, I would prefer to discuss my Social History directly with my doctor

Do you drive? NO/YES If yes, do you have any visual difficulty when driving? NO/YES If yes, please describe: _____

Do you smoke/吸烟? NO/YES If yes, type/amount/how long: _____

Do you drink alcohol? NO/YES If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: NO/YES, Gonorrhea/Hepatitis/HIV/Syphilis

Review of Systems

Do **you** currently, or have you ever had any problems in the following areas:

All normal

	No	Yes	?		No	Yes	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss / Gain	___	___	___	Allergies/Hay fever	___	___	___
INTEGUMENTARY (SKIN)	___	___	___	Sinus Congestion	___	___	___
NEUROLOGICAL				Runny Nose	___	___	___
Headaches/頭痛	___	___	___	Chronic Cough	___	___	___
Migraine/偏頭痛	___	___	___	Dry Throat / Mouth	___	___	___
Seizure/癲癇	___	___	___	RESPIRATORY			
EYES				Asthma/哮喘	___	___	___
Loss of Vision	___	___	___	Bronchitis	___	___	___
Blurred Vision	___	___	___	Emphysema	___	___	___
Distorted Vision/Halos	___	___	___	VASCULAR/CARDIOVASCULAR			
Loss of Side Vision	___	___	___	Diabetes/糖尿病	___	___	___
Double Vision	___	___	___	High Blood Pressure/高血壓	___	___	___
Dryness	___	___	___	High Cholesterol高膽固醇	___	___	___
Mucous Discharge	___	___	___	Vascular Disease/中風/心臟病	___	___	___
Redness	___	___	___	GASTROINTESTINAL			
Sandy or Gritty Feeling	___	___	___	Diarrhea	___	___	___
Itching	___	___	___	Constipation	___	___	___
Burning	___	___	___	GENITOURINARY			
Foreign Body Sensation	___	___	___	Genitals/Kidney/Bladder	___	___	___
Excess Tearing/Watering	___	___	___	BONES/JOINTS/MUSCLES			
Glare/Light Sensitivity	___	___	___	Rheumatoid Arthritis/關節炎	___	___	___
Eye Pain or Soreness	___	___	___	Muscle Pain	___	___	___
Stye or Chalazion	___	___	___	Joint Pain	___	___	___
Flashes in Vision	___	___	___	HEMATOLOGIC/LYMPHATIC			
Floaters in Vision	___	___	___	Anemia	___	___	___
Tired Eyes	___	___	___	Bleeding Problems	___	___	___
ENDOCRINE				ALLERGIC / IMMUNOLOGIC	___	___	___
Thyroid/Other Glands/甲状腺	___	___	___				
PSYCHIATRIC	___	___	___				

Patient Information: *Dilation eye drops are used to evaluate ocular health as a part of comprehensive eye exam. Please let your doctor know if you are unable to be dilated.*

Permission to dilate: NO / YES

**Please see dilation waiver form for detailed info on the importance and the /side effects of dilation drops*

While retinal photography does not replace dilated eye exam, it is strongly recommended that you have your photos taken for a more thorough eye health evaluation if you decline dilation. The cost of photos is \$39.

Permission for photo: NO / YES

Patient's Signature: X _____ "I certify that the information I provided is true and that I understand that I am responsible for payment if my insurance has declined payment for any of the services I received."

Doctor's Signature: X _____