❑ FRAMINGHAM OPTICAL
44 Union Ave., Framingham, MA 01702
P: 508.875.9636 F:508.875.3770

❑ COMFORT VISION
543 Washington St., Quincy MA 02169
P: 617.657.0205 F:617.657.0206

❑ QUINCY SHORE EYE CARE
60-A Quincy Shore Dr., Quincy MA 02171
P: 617.302.3644 F:617.302.4245

❑ LILLY EYE CARE
328 Washington St., #3, Wellesley MA 02481
P:781.235.6273 F:781.235.7645

MEDICAL HISTORY QUESTIONNAIRE

Name: ____________________________________ Sex: M / F Home Phone#:______________________

Address:____ Cell/Work Phone#:___________________

____ Occupation:_________________________

Birth Date:_________________ SSN#: ________________ Last Eye Exam: _______________________

Email:____ Last Medical Exam:___________________

Medical Doctor (PCP): Name: __________________________ Phone#:_________________Fax#:__________________

MEDICAL HISTORY:

Do you have allergies to any medications? ❑ No ❑ Yes If yes, explain:___________________________________

____

List any medications that you take (including oral contraceptives, aspirin, over-the-counter medications and hone remedies):

____

____

____

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

____

Circle any of the following that you have had:

Cross eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, eye injury

If female, are you pregnant or nursing? ❑ No ❑ Yes

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your current pair of lenses?_________________

Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your current pair of contacts?_______________

Types of contact lenses: ❑ Rigid ❑ Soft ❑ Extended wear ❑ Other Are they comfortable?______________

REVIEW OF SYSTEMS:

Do you currently have or do you chronically suffer from problems in any of the following areas?

		NO	YES	?
EYES	Loss of vision/side vision	❑	❑	❑
	Blurry vision	❑	❑	❑
	Distorted Vision/Halos	❑	❑	❑
	Double vision	❑	❑	❑
	Dryness	❑	❑	❑
	Mucus Discharge	❑	❑	❑
	Redness	❑	❑	❑
	Sandy/Gritty Feeling	❑	❑	❑
	Itching	❑	❑	❑
	Burning	❑	❑	❑
	Foreign Body Sensation	❑	❑	❑
	Excess Tearing/Watering	❑	❑	❑
	Glare/Light Sensitivity	❑	❑	❑
	Eye Pain/Soreness	❑	❑	❑
	Chronic Infection	❑	❑	❑
	Sties or Chalazion	❑	❑	❑
	Flashes/Floaters in vision	❑	❑	❑
	Tired Eyes	❑	❑	❑
ENDOCRINE	Thyroid/Other Glands	❑	❑	❑
CONSTITUTIONAL	Fever,Weight Loss/Gain	❑	❑	❑
NEUROLOGICAL	Headache/Migraines	❑	❑	❑
	Seizures	❑	❑	❑
PSYCHIATRIC		❑	❑	❑

		NO	YES	?
EARS, NOSE, MOUTH, THROAT				
	Allergies/Hay Fever	❑	❑	❑
	Sinus congestion	❑	❑	❑
	Chronic cough	❑	❑	❑
	Dry throat/mouth	❑	❑	❑
RESPIRATORY				
	Asthma	❑	❑	❑
	Chronic bronchitis	❑	❑	❑
	Emphysema	❑	❑	❑
VASCULAR/CARDIO-VASCULAR				
	Diabetes	❑	❑	❑
	Heart Pain	❑	❑	❑
	High Blood Pressure	❑	❑	❑
	Vascular Disease	❑	❑	❑
GASTRO-INTESTINAL		❑	❑	❑
GENITO-URINARY				
	Genitals/Kidney/Bladder	❑	❑	❑
BONES/JOINTS/MUSCLES				
	Rheumatoid Arthritis	❑	❑	❑
LYMPHATIC/HEMATOLOGIC				
	Anemia/Bleeding problems	❑	❑	❑
INTEGUMENTARY (Skin)		❑	❑	❑
ALLERGIC/IMMUNOLOGIC		❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain:

____

____

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

FAMILY HISTORY:

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	Relationship to you
Blindness	❑	❑	❑	___________________________________
Cataract	❑	❑	❑	___________________________________
Crossed Eyes	❑	❑	❑	___________________________________
Glaucoma	❑	❑	❑	___________________________________
Macular Degeneration	❑	❑	❑	___________________________________
Retinal Detachment/Disease	❑	❑	❑	___________________________________
Arthritis	❑	❑	❑	___________________________________
Cancer	❑	❑	❑	___________________________________
Heart Disease	❑	❑	❑	___________________________________
High Blood Pressure	❑	❑	❑	___________________________________
Kidney Disease	❑	❑	❑	___________________________________
Diabetes	❑	❑	❑	___________________________________
Other: _____________________________	❑	❑	❑	___________________________________
_____________________________	❑	❑	❑	___________________________________
_____________________________	❑	❑	❑	___________________________________
_____________________________	❑	❑	❑	___________________________________
_____________________________	❑	❑	❑	___________________________________

SOCIAL HISTORY:

This information is kept strictly confidential. However, you may discuss this section directly with your doctor if you prefer.

❑ *Yes, I would prefer to discuss my Social History information directly with my doctor (check box)*

Do you drive ?	❑ No	❑ Yes	If Yes, do you have visual difficulty when driving?_______________
Do you use tobacco products?	❑ No	❑ Yes	If Yes, type/amount/how long: _______________________________
Do you drink alcohol?	❑ No	❑ Yes	If Yes, type/amount/how long: _______________________________
Do you use illegal drugs?	❑ No	❑ Yes	If Yes, type/amount/how long: _______________________________

Please check any of the following that you have been exposed to or infected with:

❑ Gonorrhea ❑ Hepatitis ❑ HIV

❑ Syphilis ❑ None

This form is fill by:

❑ Patient:

____ ______________

Signature Date

❑ Guardian:

____ ______________

Signature Date

__________________________________ ________________________________

Relationship to patient Print Name

Doctor's signature: ___________________________________Reviewed by doctor on: ____________________

Date

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