



Medical History Questionnaire

PATIENT INFORMATION (PLEASE PRINT)

Name _____ Name You Want To Be Called _____ Date _____
(Mr., Mrs., Ms., Dr., Master)

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Marital Status _____ Spouse Name _____

Employer/School _____ Occupation _____ Work Phone _____

Date of Birth ___/___/___ Age _____ Sex Male Female Social Security _____ - _____ - _____

Family Doctor's Name _____ How Long Since Last Medical Exam? _____

How Long Ago Was Your Last Eye Exam _____ Where _____

Family Members Who Are Patients of Dr. Steinhauser _____ Relationship _____

MEDICAL HISTORY

Do you have any allergies to medication? No yes If yes, explain: _____

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

List all major surgeries and/or hospitalizations you have had: _____

Circle any of the following that you have or had : Crossed Eyes Lazy Eye Drooping Eyelid Prominent Eyes Glaucoma,
Retinal Disease Cataracts Eye Infections Eye Injury

Women: Are you pregnant and /or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses ? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses ? _____

What type of contact lenses do you wear? Soft Extended Wear Rigid Other Are they comfortable? yes no

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? yes no If so, do you have visual difficulty when driving? yes no If yes, describe:

Do you use tobacco products? yes no If yes, type/amount/how long: _____

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

Do you use illegal drugs? yes no If yes, type/amount/how long: _____

Have you ever been exposed to or infected with; HIV, Hepatitis, Gonorrhea, Syphilis? no yes If yes, describe which one(s):

*** PLEASE TURN 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	RELATIONSHIP TO YOU	DISEASE / CONDITION	RELATIONSHIP TO YOU
Blindness	_____	Cataracts	_____
Crossed Eyes	_____	Glaucoma	_____
Macular Degeneration	_____	Retinal Detachment	_____
Arthritis	_____	Cancer	_____
Diabetes	_____	Heart Disease	_____
High Blood Pressure	_____	Kidney Disease	_____
Lupus	_____	Thyroid Disease	_____
Other	_____	Other	_____

REVIEW OF SYSTEMS

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

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/ Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post- Nasal Drop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
EYES				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision /Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARIOVASCULAR			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Sandy or Gritty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENTOURINARY			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/ Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Patient's Signature

Date