Sacramento Contact Lenses & Optometry, Inc.
Medical History Questionnaire

Name_____**Today's date**_____

Spouse's/ Parent's Name_____ Parent's DOB & SS#_____

Children's Names _____

Address_____City_____Zip_____

Home Phone(_____)_____ Work Phone (_____) _____ Cell Phone (_____) _____

E-mail_____Occupation_____Employer_____

Birth Date_____ Social Security # _____Date of last eye exam_____

Name of medical Dr._____ Dr.'s phone #_____

Medical Ins. Co._____ Insurer's ID #_____Insurer's Name & D.O.B_____

Vision Ins. Co._____ Insurer's ID #_____Insurer's Name & D.O.B._____

Do You participate in a Flexible or Health spending account? YES NO

Whom may we thank for referring you? _____

Medical History

Do you have any allergies to medications? Please explain _____

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

List all major injuries, surgeries and/or hospitalizations you have had_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, and eye infections or eye injury_____

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 are your present pair of lenses? _____
Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No yes

Family History

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

Blindness	no	yes	_____
Cataract	no	yes	_____
Crossed eyes	no	yes	_____
Glaucoma	no	yes	_____
Macular Degeneration	no	yes	_____
Retinal Detachment/Disease	no	yes	_____
Arthritis	no	yes	_____
Cancer	no	yes	_____
Diabetes	no	yes	_____
Heart Disease	no	yes	_____
High Blood Pressure	no	yes	_____
Kidney Disease	no	yes	_____
Lupus	no	yes	_____
Thyroid Disease	no	yes	_____
Other_____			_____

Please turn this form over and complete side two

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

Do you drive? No yes if yes, do you have visual difficulty when driving? No yes if yes, please describe:

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_____
Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems
Do you currently, or have you ever had any problems in the following areas:

Constitutional
Fever, Weight loss/ gain no yes
Integumentary (skin) no yes
Neurological
Headaches no yes
Migraines no yes
Seizures no yes
Eyes
Loss of vision no yes
Blurred vision no yes
Distorted vision/halos no yes
Double vision no yes
Dryness no yes
Mucous discharge no yes
Redness no yes
Sandy or gritty feeling no yes
Itching no yes
Burning no yes
Foreign body sensation no yes
Excess tearing/watering no yes
Glare/light sensitivity no yes
Eye pain or soreness no yes
Chronic infection of eye or lid no yes
Sties or chalazion no yes
Flashes/ floaters in vision no yes
Tired eyes no yes
Endocrine
Thyroid/other glands no yes
Allergic/ immunologic no yes

Ears, nose, mouth, throat
Allergies/ hay fever no yes
Sinus congestion no yes
Runny nose no yes
Post-nasal drip no yes
Chronic cough no yes
Dry throat/mouth no yes
Respiratory
Asthma no yes
Chronic bronchitis no yes
Emphysema no yes
Vascular / Cardiovascular
Diabetes no yes
Heart pain no yes
High blood pressure no yes
Vascular disease no yes
Gastrointestinal
Diarrhea no yes
Constipation no yes
Genitourinary
Genitals/ Kidney/ Bladder no yes
Bones/ Joints/ Muscles
Rheumatoid arthritis no yes
Muscle pain no yes
Joint pain no yes
Lymphatic/Hematologic
Anemia no yes
Bleeding problems no yes
Psychiatric no yes

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

Signature_____**Date**_____

Dr's Signature_____**Date**_____