Medical History Questionnaire – TotalVision Eye Health Center
Drs. Mitchel & Regina Strand Date: _____

Name_____SocSec#_____
Address_____City_____State_____Zip_____
Home Phone_____Work Phone_____Cell Phone_____
Date of Birth_____Age_____Email_____
Employer (or school)_____Occupation (or Grade)_____
Spouse (Parent)_____Children's names/ages_____
Family members examined in this office _____
Referred by_____Primary Care Physician_____
Date of Last Eye Exam_____Last Eye Doctor_____
Major Reason for this Visit_____

REVIEW OF SYSTEMS Do you have a significant history or have you been treated for:

Fever, weight loss	Y N	Heart problems	Y N	Arthritis	Y N
Sinus Congestion	Y N	High Blood Pressure	Y N	Muscle/Joint pain	Y N
Chronic Cough	Y N	Vascular disease	Y N	Anemia, other	Y N
Dry throat, mouth	Y N	Asthma	Y N	Bleeding problems	Y N
Skin cancer	Y N	Emphysema	Y N	Kidney disease	Y N
Other skin problems	Y N	Ulcers	Y N	Bladder problems	Y N
Allergies/Hay fever	Y N	Intestinal disease	Y N	Anxiety	Y N
Lupus, Sjogrens, other	Y N	Headaches	Y N	Depression	Y N
Diabetes	Y N	Migraines	Y N	Insomnia	Y N
Thyroid problems	Y N	Seizures	Y N	Cancer	Y N
				Other Major Illness	Y N

List any Significant Surgery _____

LIST ANY MEDICATIONS (including oral contraceptives & over the counter medications)

_____

Are you Allergic to any Medications? _____

FAMILY HISTORY

Does anyone in your family have any general health problems?

Glaucoma	Y N	Arthritis	Y N	High Blood Pressure	Y N
Cataracts	Y N	Cancer	Y N	Stroke	Y N
Macular Degeneration	Y N	Diabetes	Y N	Kidney Disease	Y N
Blindness	Y N	Heart Disease	Y N	Thyroid Disease	Y N

SOCIAL HISTORY

Education (high school, voc school, college)_____

Do you smoke?	Y N	Have you ever had HIV/Hepatitis?	Y N	Do you use a computer?	Y N
Do you drink alcohol?	Y N	Do you drive?	Y N	Are you bothered by glare?	Y N
Are you pregnant/nursing?	Y N	Do you have vision trouble while driving?	Y N		

ARE YOU INTERESTED IN:	No Line Bifocals?	Y N	Contact Lenses?	Y N
	Thinner, lighter eyeglass lenses?	Y N	Laser Vision Correction?	Y N

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH APPLY TO YOUR EYES:

Burning	Mucous Discharge	Headaches	Eye injury/disease
Itching	Tearing/watering	Floating spots	Vision therapy
Gritty feeling	Blurred Vision	Flashing Lights	Crossed/lazy eyes
Dryness	Eye pain/soreness	Double Vision	Glare/sensitivity to light

DO YOU PARTICIPATE IN ANY OF THE FOLLOWING ACTIVITIES?

Fishing	Flying	Driving	Hunting	Shooting	Computers	Reading	Boating
Biking	Aerobics	Cards	Sewing	Crafts	Golf	Cooking	Skiing
Gardening	Television	Home Repairs	Tennis	Walking/Jogging		Other_____	

PATIENT SIGNATURE: _____ Reviewed by: _____ Date: _____