Fashion Valley Eye Care
7007 Friars Road Ste 351
San Diego, CA 92108

Medical History Questionnaire

Patient's Name: _____ Today's Date: _____/_____/_____
Email Address: _____
Address: _____ Home Phone: _____
City: _____ State: ____ Zip_____ Cell Phone: _____ Initial box ☐
Birth Date: ____/____/____ Work Phone: _____ if txt msging ok
Social Security#:_____ Occupation: _____
Name of Medical Doctor: _____ Dr.'s Phone: _____
Last Medical Exam: ____/____/____ Last Eye Exam: ____/____/____
Name of the Patient's Guardian (If Applicable): _____

Do you have vision insurance? ___no ___yes If yes, insurance carrier: _____
Do you have health insurance? ___no ___yes If yes, insurance carrier: _____
If yes to the questions above, please provide the following information:
Policy Holders Name:_____ SS#_____DOB_____
Do you have Medicare? ___no ___yes

Medical History

Do you have any allergies to medications? ___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: _____
_____

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

Are you pregnant or nursing? ___no ___ yes
Do you wear glasses? ___no ___yes If yes, how old is your present pair of lenses? _____
Do you wear contacts? ___no ___yes If yes, how old is your present pair of lenses? _____
Type of contacts: ___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:

Disease/Condition	**no**	**yes**	**?**	**Relationship to you**
Blindness	___	___	___	_____
Cataract	___	___	___	_____
Crossed Eyes	___	___	___	_____
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Detachment	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
Kidney Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____
Other_____	___	___	___	_____

Social History

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

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

Do you drive? ___no ___yes If yes, do you have visual difficulty when driving? If yes, please describe: _____

_____

Do you use tobacco? ___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		**Ears, Nose, Mouth, Throat**	
Fever, Weight loss/gain	no yes	Allergies/Hay fever	no yes
Integumentary (skin)	no yes	Sinus congestion	no yes
Neurological		Runny nose	no yes
Headaches	no yes	Post nasal drip	no yes
Migraines	no yes	Chronic cough	no yes
Seizures	no yes	Dry throat/mouth	no yes
Eyes		**Respiratory**	
Loss of vision	no yes	Asthma	no yes
Blurred vision	no yes	Chronic bronchitis	no yes
Distorted vision/halos	no yes	Emphysema	no yes
Loss of side vision	no yes	**Vascular/Cardiovascular**	
Double vision	no yes	Diabetes	no yes
Dryness	no yes	Heart pain	no yes
Mucous discharge	no yes	High blood pressure	no yes
Redness	no yes	Vascular disease	no yes
Sandy or Gritty feeling	no yes	**Gastrointestinal**	
Itching	no yes	Diarrhea	no yes
Burning	no yes	Constipation	no yes
Foreign body sensation	no yes	**Genitourinary**	
Excess tearing/watering	no yes	Genital/kidney/bladder	no yes
Glare/light sensitivity	no yes	**Bones/Joints/Muscles**	
Eye pain or soreness	no yes	Rheumatoid arthritis	no yes
Chronic infection of eye or lid	no yes	Muscle pain	no yes
Styes or chalazion	no yes	Joint pain	no yes
Flashes/Floaters in vision	no yes	**Lymphatic/Hematologic**	
Tired eyes	no yes	Anemia	no yes
Endocrine		Bleeding problems	no yes
Thyroid/ Other Glands	no yes	**Allergic/Immunologic**	no yes
		Psychiatric	no yes

If you answered yes to any of the above or have a condition not listed, please explain & list medication_____

_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* describes these uses and disclosures in detail. I acknowledge that I have received the *Notice of Privacy Practices* from Fashion Valley Eye Care

Patient's Signature: _____ Date: _____

Guardian's Name (please print): _____ Relationship to patient: _____

Guardian's Signature: _____ Date: _____

Doctor's Signature:_____ Date: _____