Medical History Questionnaire

Pikul Optometry

Patient Name: _____ Date of Birth: _____

Address: _____ City/ZIP: _____

Cell Phone: _____ Home: Phone: _____ Email: _____

When was your last eye exam? _____ By Whom? (if Walmart, which location?): _____

Do you wear contact lenses? □ No □ Yes If yes, what brand of contacts do you currently wear? _____

Review of Systems

PLEASE LIST ANY MEDICATIONS YOU CURRENTLY TAKE (RX OR OTC)	
☐ **Please check this box to indicate no medications are currently being taken** 1. 4. 2. 5. 3. 6.	
PLEASE CIRCLE ANY CONDITIONS OR ILLNESSES THAT APPLY TO YOU	
□ No □ Yes	**Ocular**: Dry Eye • Glaucoma • Cataracts • Macular Degeneration • Strabismus (crossed eyes) Amblyopia (lazy eye) • Legal Blindness • Surgery (LASIK / eye muscles / Cataract / Other)
□ No □ Yes	**Constitutional**: Developmental disabilities • Cancer
□ No □ Yes	**Ear/Nose/Throat**: Hearing loss • Sinusitis • Dry mouth
□ No □ Yes	**Neurological**: Autism Spectrum Disorder • Multiple Sclerosis • Cerebral Palsy • Migraine • Tumor
□ No □ Yes	**Psychiatric**: Depression • Anxiety • Attention Deficit • Bipolar
□ No □ Yes	**Cardiovascular**: Hypertension (high blood pressure) • Heart Disease • Vascular Disease Congestive Heart Failure • Stroke • Heart Attack
□ No □ Yes	**Respiratory**: Asthma • Bronchitis • Emphysema • Chronic Obstruction • Sleep Apnea
□ No □ Yes	**Gastrointestinal**: Chrohn's • Ulcer • Acid Reflux • Celiac Disease • Colitis
□ No □ Yes	**Genitourinary**: Kidney Disease • Prostate Disease/Cancer • Pregnant • Nursing
□ No □ Yes	**Musculoskeletal**: Arthritis • Osteoarthritis • Fibromyalgia • Osteoporosis
□ No □ Yes	**Integumentary**: Eczema • Rosacea
□ No □ Yes	**Endocrine**: Thyroid problems • Diabetes (type 2) • Diabetes (type 1)
□ No □ Yes	**Hematological/Lymphatic**: Anemia • High cholesterol
□ No □ Yes	**Allergies/Immunologic**: Environmental Allergies • Rheumatoid Arthritis • Lupus
□ No □ Yes	**Drug Allergies**: Penicillin • Sulfa • Codeine • Other (please list)

Family History (Do any of these conditions run in your immediate family?) PLEASE CIRCLE FAMILY MEMBER BELOW

- Cancer: Father Mother Brother Sister Son Daughter
- Diabetes (type 2): Father Mother Brother Sister Son Daughter
- High Blood Pressure: Father Mother Brother Sister Son Daughter
- Macular Degeneration: Father Mother Brother Sister Son Daughter
- Glaucoma: Father Mother Brother Sister Son Daughter
- Other (list both condition and relationship) _____

Do you use tobacco? □ No □ Yes If yes, how much per day? □ ½ Pack □ 1 Pack □ Vapor □ Other_____

Do you consume alcohol? □ No □ Yes If yes, how much per week? □ 1-7/week □ 8-14/week □ >15/week