Almaden Family Optometric Center
MEDICAL HISTORY QUESTIONNAIRE

Patient's Name (Last, First):_____
Eye exam Date (mm/dd/yyyy):_____
Birth Date (mm/dd/yyyy):_____
Birth Sex: Female / Male
Cell/Text Phone #:_____
Email:_____
Occupation:_____
Hobbies:_____
Purpose of today's visit_____
Last eye exam (mm/yyyy):_____

Primary Insured's Name:_____
Primary Insured's Birth Date:_____
Address:_____
_____
Vision Insurance:_____
Preferred Language:_____
Referred by:_____
Hours spent on computer/phone usage per day: _____

Personal Ocular History ***please check the box if "YES"**

- ☐ Glasses
- ☐ Contact lenses. Type:_____
- ☐ Blurry vision
- ☐ Eye pain (Right / Left eye)
- ☐ Watery eye tearing (R / L)
- ☐ Red eye (R / L)
- ☐ Distortion vision (R / L)
- ☐ Flashes seeing light (R / L)
- ☐ Black out of vision (R / L)
- ☐ Cataracts (R / L)
- ☐ Macular degeneration (R / L)
- ☐ Dryness (R / L)
- ☐ Eye strain
- ☐ Glaucoma (R / L)
- ☐ Itching (R / L)
- ☐ Retinal detachment (R / L)
- ☐ Strabismus eye turn (R / L)
- ☐ Floaters (R / L)
- ☐ Double vision
- ☐ Other:_____
- ☐ **All normal**

List any eye injury, surgery or trauma (which eye and when): _____

List any previous surgeries a**nd surgery date**: _____

List any **medication**s you take:_____

List any **allergies** and **associated allergic reactions**:_____

- ☐ No Known Drug Allergy

Social History "Please check the box if you do/have"

- ☐ *Do you smoke?*
- ☐ *Do you drink alcohol?*
- ☐ *Do you drive?*

Personal Medical History

- ☐ **All normal**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Heart disease
- ☐ Lung disease
- ☐ Depression
- ☐ Diabetes
- ☐ High blood pressure (Controlled? YES / NO)
- ☐ Hearing loss
- ☐ High cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Tumor_____
- ☐ Cancer_____
- ☐ Headache
- ☐ Stroke
- ☐ Anemia
- ☐ Pregnancy or Nursing
- ☐ Other:_____

Review of System

- ☐ **All normal**
- ☐ Eyes: loss of vision
- ☐ Neurological: migraine, headache, seizure
- ☐ Endocrine: thyroid, diabetes
- ☐ Psychiatric: depression
- ☐ Constitutional: fever, weight
- ☐ Integumentary: rash, skin
- ☐ Allergic / Immunologic
- ☐ Gastrointestinal: diarrhea, constipation
- ☐ Respiratory: cough, breathing
- ☐ Genitourinary: genital, kidney, bladder
- ☐ Cardiovascular: blood pressure
- ☐ Bones/Joints/Muscle: rheumatoid arthritis, joint pain, muscle pain
- ☐ Ear/Nose/Mouth/Throat
- ☐ Hematologic/Lymphatic: bleeding, anemia
- ☐ Other/Details:_____

Patient's Name (Last, First):_____

Family History (List Relationship: Mother, Father, etc.)

- ☐ **All normal**
- ☐ Blindness_____
- ☐ High myopia ≥ - 6.00_____
- ☐ Strabismus eye turn_____
- ☐ Amblyopia lazy eye_____
- ☐ Glaucoma_____
- ☐ Macular degeneration_____
- ☐ Retinal detachment_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ High Blood Pressure_____
- ☐ High cholesterol_____
- ☐ Other:_____

Dilation and Retinal Photographs.

Dilation and retinal photographs are done as part of a comprehensive eye examination to evaluate the health of your eyes. While retinal photographs do not replace dilation, they provide critical details to help doctors to see the back of your eyes better. Please see dilation waiver form for details on *the importance and the side effects of dilation drops (blur, sensitivity to light, etc).*

- ☐ I give the office permission to dilate my eyes with doctor's recommendation **or**
- ☐ I decline dilation
- ☐ Permission for retinal photograph with a $39 copay

Axial Length Nearsightedness Management Device

MYAH measures the precise length of your eyeball with interferometry without eye drops, ultrasound or x-ray. This test helps our doctors to better manage and track your nearsightedness prescription as eyeball elongation is highly correlated with nearsightedness progression. An eyeball length > 26mm is a risk factor of ocular complications such as retinal detachment. This makes it important for patients to get their eyeball length measured at the annual eye exam.

- ☐ Permission for axial length measurement with a $15 fee

"I certify that the information I provided is true and that I understand that I am responsible for payment if my insurance has declined reimbursements for any services rendered."

Patient or Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____