Polsinelli Optometry
MEDICAL HEALTH QUESTIONNAIRE

Patient's Name:

Reason for visit:

Do you have any allergies to medications? ❑no ❑yes
If yes, explain:
Type of reaction:
Severity:

Current prescribed medications, over the counter medications, vitamins and home remedies.

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

Primary care doctor's name and last visit:

❑Pregnant or nursing

Current vision correction
Glasses
Type:
❑Single Vision: ❑Distance ❑Reading ❑Computer
❑Bifocal
❑Progressive

Contact lenses
Brand:
❑Rigid
❑Soft
❑Overnight wear
❑Other
Are they comfortable? ❑no ❑yes
Solution brand used: ❑Opti-Free ❑Renu ❑Complete ❑Biotrue
❑Clear care ❑Boston ❑Aosept ❑Generic

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

Constitution:
- ❑Burning Pain Numbness
- ❑Fatigue
- ❑Insomnia
- ❑Weight Loss/Gain

Cardiovascular
- ❑Aneurysms
- ❑Arrhythmia
- ❑Atherosclerosis
- ❑Congestive Heart Failure
- ❑Heart Disease
- ❑High Blood Pressure
- ❑High Cholesterol

Past/present eye history:
❑Glaucoma
❑Cataracts
❑Age Related Macular Degeneration
❑Eye Injury
❑Retinal Disease
❑Blindness
❑Strabismus (eye turn)
❑Amblyopia (lazy eye)
❑Diabetic eye disease
❑Dry Eye
❑Itchy Eye
❑Other

Ears, Nose, Mouth, Throat
- ❑Benign Tumors
- ❑Dry Throat/Mouth
- ❑Hearing Loss
- ❑Herpes Zoster Oticus
- ❑Mouth Sores
- ❑Post-Nasal Drip

Respiratory
- ❑Asthma
- ❑Bronchitis
- ❑Cough
- ❑Emphysema
- ❑Pneumonia
- ❑Sleep Apnea
- ❑Tuberculosis

Gastrointestinal
- ❑ Crohn's Disease
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty Swallowing
- ❑ Hepatitis Type A, B, C
- ❑ Ulcerative Colitis

Genitourinary
- ❑ Bladder Infection
- ❑ Kidney Failure/Infections/Stones
- ❑ Urinary Tract Infections
- ❑ Sexually Transmitted Disease

Musculoskeletal
- ❑ Arthritis
- ❑ Back pain
- ❑ Bone Cancer
- ❑ Cerebral Palsy
- ❑ Gout
- ❑ Joint Pain
- ❑ Juvenile Rheumatoid Arthritis
- ❑ Muscle Cramps/Pain
- ❑ Multiple Sclerosis
- ❑ Rheumatoid Arthritis

Integumentary
- ❑ Basal Cell Carcinoma
- ❑ Dermatitis
- ❑ Eczema
- ❑ Lupus
- ❑ Psoriasis

Neurological
- ❑ Bell's Palsy
- ❑ Epilepsy
- ❑ Headaches
- ❑ Migraines
- ❑ Seizures
- ❑ Stroke
- ❑ TIA
- ❑ Vertigo

Psychiatric
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Dementia

Endocrine
- ❑ Diabetes Type 1
- ❑ Diabetes Type 2
- ❑ Hypoglycemia
- ❑ Hypothyroidism
- ❑ Hyperthyroidism

Hematologic/ Lymphatic
- ❑ Anemia
- ❑ Lymphoma
- ❑ Sickle Cell Disease

Allergic/Immunologic
- ❑ Autoimmune Disorder
- ❑ Food Allergy
- ❑ HIV/AIDS
- ❑ Leukemia
- ❑ Lupus
- ❑ Transplant

Family History/Relationship
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Age Related Macular Degeneration
- ❑ Eye Injury
- ❑ Retinal Disease
- ❑ Blindness
- ❑ Strabismus
- ❑ Amblyopia
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Disease
- ❑ Other

Social History
- ❑ Tobacco
- ❑ Drugs
- ❑ Alcohol
- ❑ Hobbies/Sports

If you answered Yes to any of the above or have a condition not listed, please explain and list medications for condition.

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