



**ELLICOTT CITY**  
TOTAL EYE CARE

5012 Dorsey Hall Drive, Suite 105  
Ellicott City, Maryland 21042  
www.ellicottcityeyes.com  
(410) 730-8878

**Medical History Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_  
Address: \_\_\_\_\_ Last Eye Doctor: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_  
Phone Number (home): \_\_\_\_\_ (work): \_\_\_\_\_ Current Medical Doctor: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Vision Insurance Plan: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
Member ID Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
Spouse: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_

**Medical History**

Do you have any allergies to medications?  Yes  No If yes, please explain \_\_\_\_\_  
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): \_\_\_\_\_

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

Are you pregnant and/or nursing?  Yes  No If yes, please explain \_\_\_\_\_  
Have you had any eye surgeries?  Yes  No If yes, please explain \_\_\_\_\_  
Have you ever had vision therapy?  Yes  No If yes, please explain \_\_\_\_\_  
Have you ever injured your eyes?  Yes  No If yes, please explain \_\_\_\_\_  
Do you wear glasses?  Yes  No If yes, how old are your current lenses? \_\_\_\_\_  
Do you wear contact lenses?  Yes  No If yes, how old are your current lenses? \_\_\_\_\_  
Type of contact lenses  Rigid  Soft  Extended wear  Other: \_\_\_\_\_  
Name of lenses: \_\_\_\_\_ Are they comfortable? \_\_\_\_\_

**Review of systems**

Do you currently, or have you ever had any problems in the following areas:

<b>Visual Systems</b>	<b>current</b>	<b>past</b>	<b>never</b>	<b>Systemic Systems</b>	<b>current</b>	<b>past</b>	<b>never</b>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urogenital (kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood (anemia, cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (thyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological (MS, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (acne, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (depression, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(asthma, bronchitis, emphysema)			
				Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Please fill out the back side*

**Social History**

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

I would prefer to discuss my Social History information directly with my doctor.

Do you drive?  Yes  No If yes, do you have visual difficulty when driving?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you use drink alcohol?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  None

What type of work do you do? \_\_\_\_\_

Do you go to school?  Yes  No If yes, where and what grade level/field of study?: \_\_\_\_\_

Do you play any sports?  Yes  No If yes, type and amount: \_\_\_\_\_

Other forms of exercise? \_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_

How many hours per day do you: Work on a computer? \_\_\_\_\_

Read? \_\_\_\_\_

Watch TV? \_\_\_\_\_

Play Video Games? \_\_\_\_\_

**Family History**

Have any of your relatives, living or deceased, had any of these conditions?

<b>Ocular Disease/Condition</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>	<b>Relationship to you</b>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Systemic Disease/Condition</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>	<b>Relationship to you</b>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*Our goal is to provide the best, most complete, up-to-date care available. Our philosophy is preventative and developmental in approach. To provide this service in the most effective manner, please be aware of the following office policies:*

- Fees for services are due at the time those services are rendered.
  - A deposit is required on all materials and balance due upon delivery.
  - We reserve the right to charge for missed appointments not cancelled in advance.
  - Visual training patients must notify us of absences in advance.
  - There is a charge for written reports.
  - Responsibility for payment is the patient's. Insurance agreements are between company and patient.
- We will assist with proper forms but require reimbursement from patients.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_