Riviera Opticare Inc. Medical History Questionnaire

Please complete both sides of this form completely and accurately.

Date: ______________________________

Patient: ______________________________ Sex:_______ State of Birth:________ Date of Birth:__________________

Employer:________________________ Occupation:______________________ Hobbies:______________________________

Cell Phone: ________________ Home Phone:______________ Work Phone:______________ E-Mail:________________________

Height :____________ Weight:____________ Race: White/ Black/Asian/Indian/Other Ethnicity: Not Hispanic/ Hispanic

Please list the following:

1) All reasons for your visit today: ____

____

2) Any VISION Problems or symptoms: (for any EYE Health symptoms please fill out **Ocular Review** on back page)____________

____

3) All medications that you currently are taking (prescription and over-the-counter):____

____

4) Preferred Pharmacy Name with phone # and major cross streets:____

5) All eye drops/ointments that you use (prescription and over-the-counter): ____

____

6) All current or prior diagnosed major illnesses (ex. eye diseases or conditions, diabetes,high blood pressure, see BACK PAGE for more details):____

____

7) All prior major injuries involving the eyes, face, head or neck: ____

____

8) Any eye surgeries that you have had with dates & which eye (ex. laser, cataract, lids, etc.):________________________________

____

9) Any other surgeries: ____

10) Do you have allergies to any medications? ____ NO /____ YES: If YES, list:____

11) Have you ever been diagnosed with Cancer? ____NO/ ____ YES: If YES, please describe:_____________________________

____

12) Do you have a disability? ____NO ____ YES: If YES, please describe:____

PAST HISTORY

Date of Last Eye Exam:___________________ Location/Dr. ____

History of Glasses wear ____Never Worn / ____ Used To Wear/ ____Currently Wear, How Many Pairs currently used? ___________

History of Contact Lens Wear:____ Never Worn/ ____ Used to Wear/ ____ Currently Wear

Are you a Computer user? ____NO/ ____ YES: if Yes : How Many Hours per Day?_____ Type Used: Lap Top/ Desk Top/Both

SOCIAL HISTORY

Do You Use Tobacco? ____ NO, If NO: ____ Never Used/ ____Used To Use (Quit)

____ YES, If YES: ____ Daily Smoker/ ____ Part Time Smoker

Do You Drink Alcohol? ____NO/ ____YES: IF YES: For BEER and WINE: ____Daily Use/____Weekly Use/____Rarely Use

IF YES: For OTHER ALCOHOL:____Daily Use/____Weekly Use/____Rarely Use

Do You Use Illegal Drugs? ____NO/____ YES: If YES, please describe:____

Please complete backside also

Review of Health Systems

*Please check YES or NO if **YOU** have a health problem in each of these health categories.*

Constitutional ☐ No ☐ Yes
__ Develop. Disability
__ Chronic Fatigue
__ Trauma
__ Other

CardioVascular ☐ No ☐ Yes
__ High BP
__ High Cholesterol
__ Stroke
__ Other

Ear/Nose/Mouth/Throat ☐ No ☐ Yes
__ Sinus Infection
__ Sinus Problem
__ Hearing Problems
__ Vertigo
__ Other

Respiratory ☐ No ☐ Yes
__ Asthma
__ Bronchitis/ Emphysema
__ Other

Gastrointestinal ☐ No ☐ Yes
__ Crohn's
__ Colitis
__ Ulcer / Digestive
__ Kidneys / Kid. Stones
__Other

Genitourinary ☐ No ☐ Yes
__ Bladder Infection
__ Prostrate
__ Sex. Transmitted Disease
__ Other

Musculoskeletal ☐ No ☐ Yes
__ Osteoarthritis
__ Fibromyalgia
__ Sjogrens
__ Musc. Dystrophy
__ Other

Skin/ Integumentary ☐ No ☐ Yes
__ Rosacea
__ Eczema
__ Psorias
__ Other

Neurological ☐ No ☐ Yes
__ Multiple Sclerosis
__ Epilepsy
__ Other

Psychiatric ☐ No ☐ Yes
__ Depression
__ Anxiety
__Schizophrenia
__ Other

Endocrine ☐ No ☐ Yes
__ Insulin-dep. Diabetes
__ Non-Insulin-dep. Diabetes
__ Thyroid disorder
__ Hormonal dysfunction

Blood/Lymphatic ☐ No ☐ Yes
__ Anemia
__ Leukemia
__ Other

Allergy/Immune ☐ No ☐ Yes
__ Drug Allergy
__Environmental Allergy
__ Other

Cancer ☐ No ☐ Yes
If yes, List Type

____

Ocular ☐ No ☐ Yes
__ Glaucoma
__ Cataracts
__ ARMD (Mac. Degen.)
__ Eye Injury
__ Retina Disease
__ Other Eye Disease
__ Blindness
__ Strabismus (Eye Turn)
__ Amblyopia
__ Diabetic Eye Disease
__ Dry Eye
__ Refractive Surgery (Laser/RK)
__ Eye Allergies

FAMILY HISTORY:
Please write the family members relationship to you (Mom ,Dad, etc.) next to the condition they have.

Ocular Review

Please check YES or NO if you have any of the listed eye problems. If YES, please provide the following details:
Which Eye / For How Long / Severity / Any Treatment / Other Details

Blurred Vision	☐ NO	☐ YES: ______________________________
Flashes of Light	☐ NO	☐ YES: ______________________________
Floaters	☐ NO	☐ YES: ______________________________
Cobwebs	☐ NO	☐ YES: ______________________________
Fluctuating Vision	☐ NO	☐ YES: ______________________________
Distorted Vision (halos)	☐ NO	☐ YES: ______________________________
Loss of Side Vision	☐ NO	☐ YES: ______________________________
Blindspots	☐ NO	☐ YES: ______________________________
Double Vision	☐ NO	☐ YES: ______________________________
Dryness	☐ NO	☐ YES: ______________________________
Mucous Discharge	☐ NO	☐ YES: ______________________________
Redness	☐ NO	☐ YES: ______________________________
Sandy or gritty feeling	☐ NO	☐ YES: ______________________________
Itching or burning	☐ NO	☐ YES: ______________________________
Problems with night vision	☐ NO	☐ YES: ______________________________
Foreign body sensation	☐ NO	☐ YES: ______________________________
Excess tearing/watering	☐ NO	☐ YES: ______________________________
Glare/light sensitivity	☐ NO	☐ YES: ______________________________
Eye pain or soreness	☐ NO	☐ YES: ______________________________
Infection of eye or lid	☐ NO	☐ YES: ______________________________
Tired eyes	☐ NO	☐ YES: ______________________________
Crossed eyes / Lazy eye	☐ NO	☐ YES: ______________________________
Drooping eyelid	☐ NO	☐ YES: ______________________________

☐ **Primary ROS taken today** ☐ **Reviewed previous ROS today from** _____/_____/_________

Doctor Signature:______________________________ ☐ Changes noted ☐ No changes