Welcome to the office of Dr. Eric A. Staffier, Doctor of Optometry

Name: _____ Age:_____ DOB:_____

Address: _____ Phone: _____

City/State/Zip: _____ Email Address: _____

Medical Insurance: _____ Vision Insurance: _____

Medical History Questionnaire

FAMILY/PERSONAL HISTORY

What problems are you currently having with your eyes? Check all that apply:

○ Blurred vision	○ Redness	○ Mucous discharge
○ Distorted vision/ Halos	○ Burning	○ Foreign body sensation
○ Loss of side vision	○ Itching	○ Sandy or gritty feeling
○ Loss of central vision	○ Dryness	○ Chronic lid infection
○ Double vision	○ Tired eyes	○ Glare/ Light sensitivity
○ Flashes/ Floating spots	○ Watering Excessively	○ Eye pain or soreness
○ Crusting on eyelashes	○ Having problems with contacts	

Do you have any of the following eye conditions? Check all that apply:

○ Blindness	○ Diabetic eye disease	○ Macular degeneration
○ Crossed eyes	○ Retinal detachment	○ Glaucoma
○ Cataracts	○ Amblyopia (lazy eye)	○ Retinal disease

Do any blood relatives have any of the following eye or medical conditions? Check all that apply:

○ Blindness	○ Glaucoma	○ Diabetic eye disease
○ Cataracts	○ Macular degeneration	○ Amblyopia (lazy eye)
○ Crossed eyes	○ Diabetes	○ High blood pressure
○ Cancer	○ Thyroid disease	○ Retinal disease
○ Retinal detachment		

○ Other_____

REVIEW OF SYSTEMS

Do you have any of the following medical conditions? Check all that apply:

○ Headaches	○ Allergies/ Hay fever	○ Asthma
○ Diabetes	○ Migraine	○ Sinus congestion
○ Chronic bronchitis	○ Heart/chest pain	○ Bleeding disorder
○ Runny nose	○ Emphysema	○ High blood pressure
○ Stroke/ Seizures	○ Cancer	○ Fever, Weight loss/gain
○ Chronic cough	○ Arthritis	○ High cholesterol
○ Thyroid disease	○ Diarrhea/ Constipation	○ Dry throat/mouth
○ Fibromyalgia	○ Psoriasis/ Rosacea	○ Kidney/bladder disease
○ Lupus	○ Depression	○ Heart disease

○ Other_____

☺ Please Turn Page Over ☺

SOCIAL HISTORY

Please answer the following, circling all that apply :

Do you drive?	Yes	No		
Do you consume alcohol?	Yes	No		
Do you use tobacco products?	Yes	No		
Are you a carrier of, or infected with:	Hepatitis	HIV	Gonorrhea/Syphilis	None
Marital/Living status?	Single	Married	Widowed	With family or friends

MEDICAL HISTORY

Please list all the medications you are taking:_____

_____

When was your last eye exam? _____where? _____

When was your last physical exam?_____

Who is your primary care physician?_____ city? _____

Are you pregnant or nursing? Yes No N/A

Are you allergic to any medications? Yes No

If so, please list:_____

List all major surgeries or injuries you have had in the past 10 years:

_____

Do you wear glasses? Yes No

Do you wish to be fitted for contact lenses or renew your contact lens prescription? Yes No

May Eric A. Staffier OD, PC remind you of upcoming appointment using a third party recall system? Yes No

_____

FOR OFFICE USE

Doctor's Signature_____ Date_____