Drs. Matoba, Optometrist
200 Union Blvd STE 41
Lakewood CO 80228

Medical History Questionnaire

Patient Name: _____

Address: _____

_____

DOS: _____ DOB: _____

Height: _____ **Weight:** _____

Home # _____ Alt# : _____

Insurance:

Your Medical Doctor Information

Doctor's Name: _____

Address: _____

_____ Zip: _____

Phone: _____

Last Medical Exam: ____/____/_____

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

	NO	YES	If yes, describe
***Constitutional**			
Fever, Weight Loss/Gain	☐	☐	_____
***Dermatological (skin)**			
Eczema	☐	☐	_____
Acne	☐	☐	_____
Other	☐	☐	_____
***Neurological**			
Headaches	☐	☐	_____
Migraines	☐	☐	_____
Seizures	☐	☐	_____
Stroke	☐	☐	_____
Other	☐	☐	_____
***Eyes**			
Blurred Vision	☐	☐	_____
Loss of Vision	☐	☐	_____
Drooping eyelid	☐	☐	_____
"Lazy eye"	☐	☐	_____
Eye Turn	☐	☐	_____
Cataracts	☐	☐	_____
Eye infections	☐	☐	_____
Chronic Infections of eyelid	☐	☐	_____
Glaucoma	☐	☐	_____
Retinal disease	☐	☐	_____
Eye injuries	☐	☐	_____
Other	☐	☐	_____
Infectious Disease			
Hepatitis	☐	☐	_____
HIV	☐	☐	_____
Tuberculosis	☐	☐	_____
Herpes	☐	☐	_____
Syphilis	☐	☐	_____
Other	☐	☐	_____
***Bones / Joints / Muscles**			
Arthritis	☐	☐	_____
Other	☐	☐	_____
***Psychiatric**			
Depression or Anxiety	☐	☐	_____
Other	☐	☐	_____

	NO	YES	If yes, descr
***Allergies**			
Seasonal/Environmental	☐	☐	_____
Drug	☐	☐	_____
Other	☐	☐	_____
***Ears, Nose, Mouth, Throat**			
Sinus Congestion	☐	☐	_____
Dry Throat / Mouth	☐	☐	_____
Chronic Cough	☐	☐	_____
Other	☐	☐	_____
***Respiratory**			
Asthma	☐	☐	_____
Chronic Bronchitis	☐	☐	_____
Other	☐	☐	_____
***Cardiovascular**			
Angina	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Other	☐	☐	_____
***Gastrointestinal**			
Diarrhea/Constipation	☐	☐	_____
GERD	☐	☐	_____
Other	☐	☐	_____
***Genitourinary**			
Genital / Kidneys / Bladder	☐	☐	_____
Other	☐	☐	_____
***Endocrine**			
Diabetes	☐	☐	_____
Thyroid / Other Glands	☐	☐	_____
Other	☐	☐	_____
***Lymphatic / Hematologic**			
Anemia	☐	☐	_____
Bleeding Problems	☐	☐	_____
Other	☐	☐	_____
Immunologic			
Sarcoidosis	☐	☐	_____
Lupus	☐	☐	_____
Other	☐	☐	_____
Cancer	☐	☐	_____

Please complete other side

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: _____

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

_____

_____

Are you pregnant and/or nursing? ☐ **No** ☐ **Yes**

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear (sleep in contacts?) ☐ Other Are they comfortable? ☐ No ☐ Yes

Social History

This information is kept strictly confidential. However, you may discuss this directly with your doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe: _____

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

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you use recreational drugs? ☐ No ☐ Yes If yes, type/amount/how long: _____

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

DISEASE /CONDITION	NO	YES	Relationship To You
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Stroke	☐	☐	_____
Other _____	☐	☐	_____

_____ _____

Patient's Signature Date