L.A. VISION OPTOMETRY

Medical History Questionnaire

Name: 姓名: _____ Today's Date: 日期: ____ / ____ / ____

Address: 地址: _____ Phone: 電話: _____

City: 城市: _____ Zip: 區號: _____ Work Phone: 工作電話: _____

Guardian (If Applicable): 監護人(兒童): _____ Occupation: 職業: _____

Birth Date: 生日: ____ / ____ / ____ Social Security # : 社安號: ____ / ____ / ____ Last Eye Exam: 上次眼檢日: ____ / ____ / ____

Name of Medical Doctor: 家庭醫生姓名: _____ Dr.'s Phone: 醫生電話: _____

How did you learn about us? 如何認識我們公司的? _____ Last Medical Exam: 上次體檢日: ____ / ____ / ____

Medical History

Do you have any allergies to medications? 藥物過敏? ❒ no 否 ❒ yes 是 If yes, explain: 過敏現象: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): 現服藥物:

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: 曾經重傷, 手術, 重病等歷史: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, 列出眼疾傷害等歷史: 斜視, 弱視, 眼瞼下垂, 眼球突出, 青光眼, 視網膜疾病, 白內障或眼睛傷害

eye infections or eye injury: _____

Are you pregnant and/or nursing? 懷孕或哺乳?	❒ no 否	❒ yes 是
Do you wear glasses? 帶眼鏡?	❒ no 否	❒ yes 是
Do you wear contact lenses? 帶隱形眼鏡?	❒ no 否	❒ yes 是
Type of contact lenses: 隱形鏡片:	❒ Rigid 硬式	❒ Soft 軟式

Family History 疾病家史

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:
請注明下列疾病家史 (父母, 祖父母, 兄弟姐妹, 孩子, 在生或死亡親屬)

DISEASE/CONDITION 病狀	NO 否	YES 是	?	RELATIONSHIP TO YOU 家屬關係
Blindness 盲眼	❒	❒		
Cataract 白內障	❒	❒		
Crossed Eyes 斜視	❒	❒		
Glaucoma 青光眼	❒	❒		
Macular Degeneration 黃斑老化	❒	❒		
Retinal Detachment/Disease 視網膜	❒	❒		
Arthritis 風濕	❒	❒		
Cancer 癌症	❒	❒		
Diabetes 糖尿病	❒	❒		
Heart Disease 心臟病	❒	❒		
High Blood Pressure 高血壓	❒	❒		
Kidney Disease 腎臟病	❒	❒		
Lupus 免疫系統	❒	❒		
Thyroid Disease 淋巴	❒	❒		

** Please turn this form over and complete side two **

Social History
生活狀況

Do you drive? ☐ no ☐ yes
駕車? 否 是

Do you use tobacco products? 抽煙? ☐ no 否 ☐ yes 是 If yes, type/amount/how long: _____
如是, 何種/數量/多久:

Do you drink alcohol? 酗酒? ☐ no 否 ☐ yes 是 If yes, type/amount/how long: _____
如是, 何種/數量/多久:

Do you use illegal drugs? 吸毒? ☐ no 否 ☐ yes 是 If yes, type/amount/how long: _____
如是, 何種/數量/多久:

Have you ever been exposed to or infected with: ☐ Hepatitis ☐
曾感染: 肝炎 性病

Review of Systems 健康現狀

Do you currently, or have you ever had any problems in the following areas: 現在或曾經有以下病症:

SYSTEM 身體	NO 否	YES 是	? ?
Fever, Weight Loss/Gain 發燒體重起伏	☐	☐	☐
Skin 皮膚病	☐	☐	☐
Migraines 偏頭痛	☐	☐	☐
Seizures 癲癇	☐	☐	☐
EYES 眼睛			
Loss of Vision 弱視	☐	☐	☐
Blurred Vision 模糊	☐	☐	☐
Distorted Vision/Halos 視力扭曲/色圈	☐	☐	☐
Loss of Side Vision 視野不清	☐	☐	☐
Double Vision 雙重視	☐	☐	☐
Dryness 眼乾	☐	☐	☐
Mucous Discharge 分泌物外溢	☐	☐	☐
Redness 紅眼	☐	☐	☐
Sandy or Gritty Feeling 乾澀	☐	☐	☐
Itching 癢	☐	☐	☐
Burning 刺痛	☐	☐	☐
Excess Tearing/Watering 流淚	☐	☐	☐
Glare/Light Sensitivity 畏光	☐	☐	☐
Eye Pain or Soreness 酸痛	☐	☐	☐
Chronic Infection of Eye or Lid 發炎	☐	☐	☐
Sties or Chalazion 針眼	☐	☐	☐
Flashes/Floaters in Vision 飛蚊	☐	☐	☐
Tired Eyes 疲勞	☐	☐	☐
ENDOCRINE 內分泌			
Thyroid/Other Glands 淋巴	☐	☐	☐

	NO 否	YES 是	? ?
EARS, NOSE, MOUTH, THROAT 耳, 鼻, 喉			
Allergies/Hay Fever 過敏	☐	☐	☐
Sinus Congestion 鼻竇充血	☐	☐	☐
Runny Nose 流鼻涕	☐	☐	☐
Chronic Cough 慢性咳	☐	☐	☐
Dry Throat/Mouth 喉/口乾	☐	☐	☐
RESPIRATORY 呼吸係統			
Asthma 哮喘	☐	☐	☐
Chronic Bronchitis 慢性支氣管炎	☐	☐	☐
Emphysema 肺氣腫	☐	☐	☐
VASCULAR / CARDIOVASCULAR 心血管係統			
Diabetes 糖尿病	☐	☐	☐
Heart Pain 心臟病	☐	☐	☐
High Blood Pressure 高血壓	☐	☐	☐
Vascular Disease 血栓	☐	☐	☐
GASTROINTESTINAL 消化係統			
Diarrhea 腹瀉	☐	☐	☐
Constipation 便秘	☐	☐	☐
BONES / JOINTS / MUSCLES 骨骼/關節/肌肉			
Rheumatoid Arthritis 風濕	☐	☐	☐
Muscle Pain 肌肉痛	☐	☐	☐
Joint Pain 關節痛	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia 貧血	☐	☐	☐
Bleeding Problems 出血問題	☐	☐	☐
ALLERGIC / IMMUNOLOGIC 過敏/免疫	☐	☐	☐
PSYCHIATRIC 心理障礙	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:
以上列出豁未有列出之病狀及現服之藥品請說明.

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature 醫生簽名 Date 日期