

Medical History Questionnaire

Name _____ Today's Date _____

What is the main reason for today's exam? _____

Approximately when was your last eye exam? _____

Do you have any allergies to medications? Yes No

If yes, explain: _____

List any medications you take (including aspirin, over the counter medications & home remedies), and state reason for taking the medication:

1) _____	Reason _____	5) _____	Reason _____
2) _____	Reason _____	6) _____	Reason _____
3) _____	Reason _____	7) _____	Reason _____
4) _____	Reason _____	8) _____	Reason _____

Primary Care doctor: _____ Phone: _____

Ophthalmologist or referring doctor (if any): _____ Phone: _____

List major injuries and prior surgeries you have had:

Are you pregnant and/or nursing? Yes No

Do you wear glasses (check all that apply): None Reading Distance Computer
Safety Sports Bifocals Trifocals Progressives (no-line)

Do you wear contact lenses? None Rigid Soft Lenses/Disposables
Extended Wear Are they comfortable? Yes No

Type/Brand: _____

If using disposable lenses, how often do you discard them? (ex: dispose every 2 weeks): _____

What duration of time are contacts worn? (ex: Mon-Fri from 6:30am - 7:00pm): _____

SOCIAL HISTORY

Hobbies / Interests: _____

Do you drive? Yes No

If yes, do you have visual difficulty when driving? (please specify): _____

Do you use tobacco products? Yes No

If yes, type/amount/how long: _____

Do you drink alcohol? Yes No

If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No

If yes, type/amount/how long: _____

GENERAL HEALTH CONDITION

Do you have or ever had any problems in the following areas?

AIDS/HIV	Yes	No	Heart disease	Yes	No
Allergies/Hay Fever	Yes	No	High Blood Pressure	Yes	No

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Asthma	Yes	No	Cholesterol	Yes	No
Thyroid Condition	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Headaches	Yes	No	Diabetes	Yes	No
Migraines	Yes	No	Arthritis	Yes	No

EYE HISTORY

Loss of Vision	Yes	No	Excess Tearing/Watering	Yes	No
Blurred Vision Distance	Yes	No	Glare/Light Sensitivity	Yes	No
Blurred Vision Near	Yes	No	Eye Pain or Soreness	Yes	No
Loss of Side Vision	Yes	No	Chronic Infection of Eye or Lid	Yes	No
Double Vision	Yes	No	Sties or Chalazion	Yes	No
Dryness	Yes	No	Flashes/Floaters in Vision	Yes	No
Mucous Discharge	Yes	No	Tired Eyes	Yes	No
Redness	Yes	No	Cataracts	Yes	No
Sandy or Gritty Feeling	Yes	No	Retinal Detachment	Yes	No
Itching	Yes	No	Macular Degeneration	Yes	No
Burning	Yes	No			

FAMILY HISTORY

To the best of your knowledge, please note any family history (parents, grandparents, siblings, children) for the following conditions:

Condition			Relationship to You
Amblyopia (Lazy Eye)	Yes	No	_____
Blindness	Yes	No	_____
Color Blindness	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Strabismus (eye turn)	Yes	No	_____
Retinal Detachment	Yes	No	_____
Diabetes	Yes	No	_____
High Blood Pressure	Yes	No	_____
Cholesterol	Yes	No	_____
Lupus	Yes	No	_____
Thyroid Disease	Yes	No	_____
Cancer	Yes	No	_____

If yes, state type of cancer: _____

Thank you for your confidence