Medical History Questionnaire

Name: ______________________________ Today's Date: ________________

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

Approximately when was your last eye exam? __________ Any allergies to medications? Yes No

If allergic to medications, explain: ______________________________

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

1) ____________ Reason ____________
2) ____________ Reason ____________
3) ____________ Reason ____________
4) ____________ Reason ____________
5) ____________ Reason ____________
6) ____________ 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 ☐ Safety ☐ Sports ☐ Computer
☐ Bifocals ☐ Trifocals ☐ Progressives (no-line bifocals)

Do you wear contact lenses?

☐ None ☐ Rigid ☐ Soft Lenses/Disposables ☐ Extended Wear

Contacts Type/Brand: ____________________ Are they comfortable? ☐ Yes ☐ No

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/amt/how long: ____________

Do you drink +2 alcoholic beverages/day? ☐ Yes ☐ No If yes, type/amt/how long: ____________

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amt/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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Condition	Yes	No	Condition	Yes	No
Asthma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Thyroid Condition	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No			

If yes, please state type of cancer: ______________________________

EYE HISTORY

Condition	Yes	No	Condition	Yes	No
Amblyopia (lazy eye)	☐ Yes	☐ No	Itching	☐ Yes	☐ No
Strabismus (eye turn)	☐ Yes	☐ No	Burning	☐ Yes	☐ No
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	Tired Eyes	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	Sties or Chalazion	☐ Yes	☐ No
Color Blindness	☐ Yes	☐ No	Flashes/Floater in Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Lasik	☐ Yes	☐ No
Dryness	☐ Yes	☐ No	Cataracts/ Surgery	☐ Yes	☐ No
Mucous Discharge	☐ Yes	☐ No	Retinal Detachment/Holes	☐ Yes	☐ No
Redness	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Sandy or Gritty Feeling	☐ Yes	☐ No	Glaucoma	☐ 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	____________
High Cholesterol	☐ Yes	☐ No	____________
Lupus	☐ Yes	☐ No	____________
Thyroid Disease	☐ Yes	☐ No	____________
Cancer	☐ Yes	☐ No	____________

If yes, please state type of cancer: ______________________________

Thank you for your confidence