MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ Today's Date:_____
Last Eye Exam:_____ **Last Physical/Medical Exam**:_____
Primary Medical Doctor:_____ Dr.'s Phone #_____
Do you have **any allergies to medications**? NO__ YES__; If yes, explain:_____

List any **medications** you take (include oral contraceptives, aspirin, over the counter medications and home remedies):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

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

Are you **pregnant and/or nursing**? NO___ YES___

EYES:

Do you wear **glasses**? NO__ YES__ If yes, how old are your lenses?_____
Do you wear **contact lenses**? NO__YES__ If yes, how old are your lenses?_____
Type of contact lenses? Rigid__ Soft__ Daily Wear__ Extended Wear__ Other_____
What solutions do you use to clean your contact lenses? _____
What eye drops do you use? _____ How often? _____
Are your contact lenses comfortable? _____
Are you interested in ***color contact lenses***? NO __ YES__
Have you had any eye infection and/or eye surgeries: NO__ YES__; Explain:_____

Are you interested in **Laser Surgery Correction**? NO__ YES__

Do you currently, or have you ever had any problems in the following areas:

Loss of Vision	NO__ YES__	Dryness	NO__ YES__
Blurred Vision	NO__ YES__	Redness	NO__ YES__
Distorted Vision/Haloes	NO__ YES__	Itching	NO__ YES__
Loss of Side Vision	NO__ YES__	Burning	NO__ YES__
Double Vision	NO__ YES__	Sandy or Gritty	NO__ YES__
Tired Eyes	NO__ YES__	Foreign Body Sense	NO__ YES__
Glare/Light Sensitivity	NO__ YES__	Excess Tears/Water	NO__ YES__
Eye Pain or Soreness	NO__ YES__	Mucous Discharge	NO__ YES__
Flashes / Floaters in vision	NO__ YES__	Sties or Chalazion	NO__ YES__
Crossed/Lazy Eye	NO__ YES__	Chronic Infection of Eye Lid	NO__ YES__
Glaucoma	NO__ YES__	Cataract	NO__ YES__
Drooping Eyelid	NO__ YES__	Retinal Disease	NO__ YES__

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This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer: Check here if you do:_____

Do you **drive**? NO__ YES__ If yes, do you have visual difficulty when driving? 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 **illegal drugs**? NO__ YES__ If yes, type/amount/ how long:_____

Have you been exposed to or infected with: Hepatitis__ HIV__ Syphillis__ Herpes__

Please, check any medical condition you have:

Fever,Weight Loss/Gain	NO__ YES__	Allergies/Hay Fever	NO__ YES__
Headaches	NO__ YES__	Sinus Congestion	NO__ YES__
Migraines	NO__ YES__	Dry Throat/Mouth	NO__ YES__
Seizures	NO__ YES__	Post Nasal Drip	NO__ YES__
Rheumatoid Arthritis	NO__ YES__	Asthma	NO__ YES__
Muscle Pain	NO__ YES__	Chronic Bronchitis	NO__ YES__
Joint Pain	NO__ YES__	Emphysema	NO__ YES__
Diabetes	NO__ YES__	Diarrhea	NO__ YES__
High Blood Pressure	NO__ YES__	Constipation	NO__ YES__
Heart disease	NO__ YES__	Kidney/Bladder	NO__ YES__
Vascular Diseases	NO__ YES__	Anemia	NO__ YES__
Thyroid Gland	NO__ YES__	Bleeding problems	NO__ YES__
Cancer	NO__ YES__ If yes, explain:_____		

Other; Please, explain & list medications:_____

_____

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

Blindness NO__ YES__ Relation to you_____		Diabetes	NO__ YES__
Glaucoma NO__ YES__ Relation to you_____		Hypertension	NO__ YES__
Macula Degen NO__ YES__ Relation to you_____		Heart Disease	NO__ YES__
Retinal Detach NO__ YES__ Relation to you_____		Cancer	NO__ YES__
Crossed Eyes NO__ YES__ Relation to you_____		Lupus	NO__ YES__
Thyroid Dis. NO__ YES__ Relation to you_____		Multiple Sclerosis	NO__ YES__

Other:_____