

Medical History Questionnaire

Large Print

Type or write your answers. Print, sign where indicated, and bring to your visit.

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)

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

Check here if you do: Yes

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 / Syphilis / 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: