Medical History Questionnaire

Please complete the **BOTH SIDES** of this questionnaire to help your doctor determine your risk for eye health problems and help you see better. All information is kept strictly confidential.

Name _____ Today's Date _____/_____/_____

Occupation _____ Do you use a computer? □ Yes □ No

Last Eye Exam (if elsewhere)_____/_____/_____ with Dr. _____

Your Medical Doctor _____ Last Medical Exam _____/_____/_____

Are you allergic to any medications? □ Yes □ No If yes, what? _____

What medications do you currently take (including aspirin, oral contraceptives, over the counter

medications and eye drops)? _____

_____

What major injuries and surgeries have you had (including eye injury and surgery)?

_____

_____

If female, are you pregnant or nursing? □ Yes □ No

Do you have prescription glasses? □ Yes □ No If yes, how old are your present lenses? _____
Do you wear contact lenses? □ Yes □ No If yes, how old are your present lenses? _____
If no, are you interested in wearing contact lenses? □ Yes □ No
Are you interested in refractive surgery (LASIK)? □ Yes □ No
Do you drive? □ Yes □ No
If yes, do you have any visual difficulty when driving? □ Yes □ No

Do you use tobacco products? □ Yes □ No If yes, list type/amount/how long _____
Do you drink alcohol? □ Yes □ No If yes, list type/amount/how long _____
Do you use illegal drugs? □ Yes □ No If yes, list type/amount/how long _____

Family History

Do any of your blood relatives (parents, grandparents, or siblings, living or deceased) have the following:

Disease/Condition	Yes	No	If yes, then relationship to you
Blindness	□	□	_____
Crossed Eyes/Lazy Eye	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment	□	□	_____
Retinal Disease	□	□	_____

→→ Please turn form over and complete side two ←←

Your Medical History

Do YOU *now* have any of the following?
Please check "yes" or "no" for each condition.

EYES	YES	NO
Blurred Vision		
Distorted Vision		
Loss of Side Vision		
Double Vision		
Dryness of Eyes		
Sandy or Gritty Feeling		
Redness of Eyes		
Itchy Eyes		
Burning/Stinging		
Watering/Excess Tearing		
Glare/Light Sensitivity		
Flashes or Floaters in Vision		

Do YOU now have or in the past have you had any of the following?

EYES	YES	NO
Crossed Eyes		
Lazy Eye		
Glaucoma		
Retinal Detachment		
Retinal Disease		
Cataracts		
Eye Surgery		
MUSCULOSKELETAL		
Rheumatoid Arthritis		
Joint Pain		
NEUROLOGICAL		
Multiple Sclerosis		
Headaches		
Migraines		
Seizures		
ENDOCRINE		
Thyroid		
Grave's Disease		
Diabetes		
EARS, NOSE, MOUTH, THROAT		
Sinus Problems		
Chronic Cough		
Dry Throat/Mouth		
RESPIRATORY		
Asthma		
Emphysema/COPD		
Tuberculosis		
ALLERGIC/IMMUNOLOGIC		
Hay Fever/Allergies		
Lupus		
HIV/AIDS		
CARDIOVASCULAR		
Heart Attack		
Other Heart Problems		
High Blood Pressure		
Stroke		
Circulatory Problems		
GASTROINTESTINAL		
Intestinal/Bowel Problems		
GENITOURINARY		
Kidney Disease		
Hepatitis		
Syphilis		
SKIN		
Skin Condition		
HEMATOLOGICAL/LYMPHATIC		
Anemia		
Bleeding Problems		
Cancer		
PSYCHIATRIC		
Depression		
Anxiety		
Mental Illness		

Please list any other medical conditions you have or give details regarding above conditions:

_____

_____

Thank you!

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FOR OFFICE USE ONLY

_____,O.D. _____/_____/_____ _____,O.D. _____/_____/_____

_____,O.D. _____/_____/_____ _____,O.D. _____/_____/_____