Medical History Questionaire

Name: _____ Today's Date: _____/_____/_____

Birth Date: _____/_____/_____ Location and Date of Last Eye Exam: _____

Name of Medical Doctor and Date of Last Exam: _____

MEDICAL HISTORY

Are you allergic to any medications? No ___ Yes___ If yes, list:_____

List any medications you are currently taking including all non-prescription meds and home remedies. If you like, please bring the list with you and we will gladly make a copy of it.

_____

_____

List all surgeries, major injuries, and hospitalizations within the past 5 years: _____

_____

Have you ever been diagnosed with any of the following eye diseases or disorders: crossed eyes, "lazy" eye, glaucoma, macular degeneration, cataracts, dry eyes, or any other diagnosis not mentioned here? Also, list and date any surgeries to your eyes.

_____

_____

Are you currently pregnant or nursing? No ___ Yes ___

Do you wear contact lenses? No ___ Yes ___ If yes, how old is your present pair? _____

What type of contact lenses do you wear? Rigid ___ Soft ___ Extended Wear ___

Do you sleep in your lenses (honestly)? No ___ Yes ___

Are you happy with the vision and comfort your lenses provide? No ___ Yes ___

Do you wear glasses? No___ Yes___ If yes, how old is your present pair of lenses? _____

Do any of the following options appeal to you?

___ Thinner/Lightweight lenses	___ Lenses that darken	___ No-line bifocals
___ Anti-Glare lenses	___ Shatter resistant lenses	___ Sunglasses
___ Contact lenses	___ Laser vision correction	___ Sports goggles

Do you drive? No ___ Yes ___ If so, do you have visual difficult while driving? No ___ Yes ___

If so, please describe: _____

Please describe your daily visual needs: include fine detailed work (crafts, sewing), hours of computer work, hobbies (woodworking, shooting, music, etc.), and sporting activities:

_____

_____

SOCIAL HISTORY

Do you drink alcohol? No___ Yes___ Do you use tobacco? No___ Yes___

Do you use illegal drugs? No___ Yes___ If 'Yes' to any, type and amount: _____

FAMILY HISTORY

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

Disease/Condition	No	Yes	?	Relationship to you
Blindness	____	____	____	_____
Cataracts	____	____	____	_____
Glaucoma	____	____	____	_____
Macular Degeneration	____	____	____	_____
Retinal Disease	____	____	____	_____
Arthritis	____	____	____	_____
Diabetes	____	____	____	_____
Heart Disease	____	____	____	_____
High Blood Pressure	____	____	____	_____
Other	____	____	____	_____

REVIEW OF SYSTEMS

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

System	No	Yes	?
CONSITUTIONAL			
Fever, Weight Loss/Gain	_____	_____	_____
INTEGUMENTARY (SKIN)			
NEUROLOGICAL			
Headaches/Migraines	_____	_____	_____
Seizures	_____	_____	_____
EYES			
Loss of Vision	_____	_____	_____
Blurry Vision	_____	_____	_____
Double Vision	_____	_____	_____
Dryness	_____	_____	_____
Distorted Vision/Halos	_____	_____	_____
Mucous Discharge	_____	_____	_____
Foreign Body Sensation	_____	_____	_____
Burning/Itching/Redness	_____	_____	_____
Excess Tearing/Watering	_____	_____	_____
Tired Eyes/Lid Twitch	_____	_____	_____
Light Sensitivity/Glare	_____	_____	_____
Eye Pain/Soreness	_____	_____	_____
Chronic Infections	_____	_____	_____
Flashes or Floaters	_____	_____	_____
ENDOCRINE			
Thyroid/Other Glands	_____	_____	_____
EAR, NOSE, THROAT			
Allergies/Hay Fever	_____	_____	_____
Sinus Congestion	_____	_____	_____
Dry Mouth	_____	_____	_____

	No	Yes	?
RESPIRATORY			
Asthma	_____	_____	_____
Bronchitis	_____	_____	_____
Emphysema	_____	_____	_____
VASCULAR			
Diabetes	_____	_____	_____
Hypertension	_____	_____	_____
High Cholesterol	_____	_____	_____
Vascular Disease	_____	_____	_____
GASTROINTESTINAL			
Crohn's Disease	_____	_____	_____
Constipation	_____	_____	_____
GENITOURINARY			
Kidney Disease	_____	_____	_____
Bladder Disorder	_____	_____	_____
STD	_____	_____	_____
BONES/JOINTS/MUSCLES			
Arthritis	_____	_____	_____
Joint Pain	_____	_____	_____
Muscle Pain	_____	_____	_____
Lower Back Pain	_____	_____	_____
BLOOD			
Anemia	_____	_____	_____
Clotting Disorder	_____	_____	_____
IMMUNOLOGIC	_____	_____	_____
PSYCHIATRIC	_____	_____	_____

If you answered 'Yes' to any of the above or have a condition not listed, please explain:

_____

_____

_____

Doctor's Signature After Review: _____