

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____
 Date of Birth ____/____/____ Social Security # _____
 Date of Last Eye Exam _____ Date of Last Medical Exam _____
 Name of Medical Doctor _____ Phone _____

Medical History

List any medications you are currently taking (including oral contraceptives and over the counter medications) _____

List all medications that you are allergic to _____

List any major surgeries (Eye or Other) or hospitalizations you have had _____

List any of the following you have had: Crossed eye, Lazy eye, Drooping eyelid, Prominent eyes, Glaucoma, Retinal disease, Cataracts, Eye injury, or Eye infections. _____

Are you pregnant or nursing? NO YES
 Do you wear glasses? NO YES If yes, how old is current pair _____
 Do you wear contact lenses? NO YES If yes, how old is current pair _____
 Type of contact lenses? Rigid Soft Extended Wear Other _____
 Hobbies which require special visual demands _____

Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions.

DISEASE/CONDITION	NO	YES	?	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

****Please turn over form and complete side two****