Medical History Questionnaire

Name:			Mr. Mrs. Ms. Miss	Today's Date:
Mailing Address:			City/State/Zip Code:	
Birth Date:	Age:	Male Female	Home Phone: ( )	Work Phone: ( )
Occupation:	Employer:	Spouse or Parent:	Cell Phone: ( )	Email:
Last Eye Exam Date:		Vision Insurance and ID/Social Security Number:		
Last Medical Exam Date:	Name of M.D.	Medical Insurance:		

A minimum deposit of ½ of your account is payable when prescription eyeglasses or contact lenses are ordered. The balance is due on delivery of the prescription.	**How will you settle your account today? Check Cash Credit Card We will only accept insurances and discounts at the time of the appointment.**

Medical History:

Do you have allergies to medications? No Yes List: ____________________

List any medications taken (***including*** oral contraceptives, aspirin, over-the-counter medications, supplements, and home remedies):

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List all major injuries, surgeries, and/or hospitalizations: ____________________

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Circle any that ***you*** have had: crossed eyes lazy eye drooping eyelid prominent eyes dry eye macular degeneration glaucoma retinal disease cataracts eye infections eye injury

Do you work at a computer for long periods? ____________________ No Yes

Do you have complaints about your glasses ? ____________________ No Yes

Would you enjoy lenses that are thinner, lighter, and more comfortable? ____________________ No Yes

Are there times when you'd rather not wear contact lenses or glasses? ____________________ No Yes

Would you like information or a free evaluation regarding laser vision correction and your candidacy? No Yes

Do you wear contact lenses? *(If yes, complete prescription information is required to perform CL exam)* No Yes

Please list hobbies/interests: ____________________

Family History:

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

DISEASE/CONDITION	No	Yes	?	RELATIONSHIP TO YOU
Blindness				
Cataract				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease				
Other				

Please turn this form over and complete side two

Social History:

Do you drive?________________________________ No Yes

- If yes, do you have visual difficulty when driving? ____________ No Yes
- If yes, 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 ever been exposed to or infected with: ❒ Hepatitis? ❒ HIV?

Review of Systems: Are you currently having any problems in the following areas?

SYSTEM	No	Yes	?		No	Yes	?
CONSTITUTIONAL:				**EAR, NOSE, MOUTH, THROAT:**			
Fever, Weight Loss/Gain	❒	❒	❒	Sinus Congestion	❒	❒	❒
SKIN DISORDERS/RASH (Integumentary)**:**	❒	❒	❒	Runny Nose	❒	❒	❒
NEUROLOGICAL:				Chronic Cough	❒	❒	❒
Headaches/Migraines	❒	❒	❒	Dry Throat/Mouth	❒	❒	❒
Seizures	❒	❒	❒	**RESPIRATORY:**			
EYES:				Asthma	❒	❒	❒
Loss of Vision	❒	❒	❒	Chronic Bronchitis	❒	❒	❒
Blurred Vision	❒	❒	❒	Emphysema	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒	**VASCULAR/CARDIOVASCULAR:**			
Loss of Side Vision	❒	❒	❒	Diabetes	❒	❒	❒
Double Vision	❒	❒	❒	Heart Pain	❒	❒	❒
Dryness	❒	❒	❒	High Blood Pressure	❒	❒	❒
Mucous Discharge	❒	❒	❒	Vascular Disease	❒	❒	❒
Redness	❒	❒	❒	**Do you have a Pacemaker**	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒	**GASTROINTESTINAL:**			
Itching	❒	❒	❒	Diarrhea	❒	❒	❒
Burning	❒	❒	❒	Constipation	❒	❒	❒
Foreign Body Sensation	❒	❒	❒	**URINARY:**			
Excess Tearing/Watering	❒	❒	❒	Kidney/Bladder Disease	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒	**BONES/JOINTS/MUSCLES:**			
Eye Pain or Soreness	❒	❒	❒	Rheumatoid Arthritis	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒	Muscle Pain	❒	❒	❒
Styes or Chalazion	❒	❒	❒	Joint Pain	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒	**LYMPHATIC/HEMATOLOGIC:**			
Tired Eyes	❒	❒	❒	Anemia	❒	❒	❒
				Bleeding Problems	❒	❒	❒
ENDOCRINE:				**ALLERGIC/IMMUNOLOGIC:**			
Thyroid/Other Glands	❒	❒	❒	Seasonal Allergies	❒	❒	❒
				PSYCHIATRIC DISORDERS:			
				Memory Loss/Depression	❒	❒	❒

If you have a condition not listed, please explain:________________________________

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Dr. Signature