

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 1/2 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? <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> 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):

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

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 or contact lenses? _____ 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

Do you spend time outdoors? _____ No Yes

Would you like information or a free evaluation regarding laser vision correction and your candidacy? 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<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"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN DISORDERS/RASH (Integumentary):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL:				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY:			
EYES:				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR:			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL:			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	URINARY:			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES:			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC:			
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE:				ALLERGIC/IMMUNOLOGIC:			
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC DISORDERS:			
				Memory Loss/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Dr. Signature