

Medical History Questionnaire

Name: _____ Today's Date: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Birth Date: _____
Social Security # _____ Last Eye Exam: _____
Occupation: _____ Work Phone: _____
Medical Doctor: _____ Dr.'s Phone: _____
Vision Insurance: _____ Last Medical Exam: _____
Responsible Party: _____ Cash Check Credit Card
If new patient, who may we thank for referring you: _____
May we contact you by e-mail? No Yes _____

Medical History

Do you have any allergies to medications? No Yes If yes, explain: _____

List any medications and the dosage you take (including bc, aspirin, over the counter, and home remedies):

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

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

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, macular degeneration, cataracts, eye infections or eye injury.

Are you pregnant and/or nursing? No Yes
Do you wear glasses? No Yes If yes, how old is your present pair of lenses?
Do you wear contacts? No Yes If yes, how old is your present pair of lenses?
Type of contact lenses: Rigid Soft Extended Wear Other
Are they comfortable? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) 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"/>	_____
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"/>	_____