Medical History Questionnaire

Woman Are you pregnant and/or nursing? No____ Yes____

Everyone

Are you an Epileptic or have a sensitivity to flashes of light? No____ Yes____
Do you have any allergies to medications? No____ Yes____ If yes, explain:_____
List any medications you take (including contraceptives, aspirin, OTC medications and home remedies)_____
_____
_____

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

_____
_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataract, eye infections or eye injuries:

_____
_____

Last eye exam: ____/____/_____
Do you wear glasses? No____ Yes____ If yes, how old is your current pair of glasses? _____
Do you wear contact lenses? No___ Yes___ If yes, how old is your current pair of lenses?_____
What type of contact lenses: Ridgid___ Soft___ Extended Wear____ Are they comfortable?_____

Family History

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

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 OVER AND COMPLETE PAGE 2

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer (please mark). _____ Yes, I would prefer to discuss my Social History information directly with the doctor.

Do you drive? No____ Yes____ If yes, do you have visual difficulty when driving? No____Yes____
If yes, please describe:_____
Do you drink alcohol? No____ Yes____ If yes, type/amount:_____
Do you use tobacco products? No____ Yes____ If yes, type/amount:_____
Do you use illegal drugs? No____ Yes____ If yes, type/amount:_____

Review of Systems

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

System:	NO	YES	?
CONSTITUTIONAL			
Fever, Weight loss/gain	_____	_____	_____
INTEGUMENTARY (SKIN)	_____	_____	_____
NEUROLOGICAL			
Headaches	_____	_____	_____
Migraines	_____	_____	_____
Seizures	_____	_____	_____
EYES			
Loss of Vision	_____	_____	_____
Blurred Vision	_____	_____	_____
Distorted Vision/Halos	_____	_____	_____
Loss of Side Vision	_____	_____	_____
Double Vision	_____	_____	_____
Diabetes	_____	_____	_____
Mucous Discharge	_____	_____	_____
Redness	_____	_____	_____
Sandy or Gritty Feeling	_____	_____	_____
Itching	_____	_____	_____
Burning	_____	_____	_____
Foreign Body Sensation	_____	_____	_____
Excess Tearing/Watering	_____	_____	_____
Glare/Light Sensitivity	_____	_____	_____
Eye Pain or Soreness	_____	_____	_____
Chronic Infection of Eyelid	_____	_____	_____
Sties of Chalazion	_____	_____	_____
Flashes/Floaters in Vision	_____	_____	_____
Tired Eyes	_____	_____	_____
ENDOCRINE			
Thyroid/Other Glands	_____	_____	_____

System:	NO	YES	?
EARS/NOSE/MOUTH/THROAT			
Allergies/Hay fever	_____	_____	_____
Sinus Congestion	_____	_____	_____
Runny Nose	_____	_____	_____
Post-Nasal Drip	_____	_____	_____
Chronic Cough	_____	_____	_____
Dry throat/Mouth	_____	_____	_____
RESPIRATORY			
Asthma	_____	_____	_____
Chronic Bronchitis	_____	_____	_____
Emphysema	_____	_____	_____
VASCULAR/CARDIOVASCULAR			
Dryness	_____	_____	_____
Heart Pain	_____	_____	_____
High Blood Pressure	_____	_____	_____
Vascular Disease	_____	_____	_____
GASTROINTESTINAL			
Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
GENITOURINARY			
Kidney/Bladder	_____	_____	_____
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	_____	_____	_____
Muscle Pain	_____	_____	_____
Joint Pain	_____	_____	_____
LYMPHATIC/HEMATOLOGIC			
Anemia	_____	_____	_____
ALLERGIC/IMMUNOLOGIC	_____	_____	_____
PSYCHIATRIC	_____	_____	_____

If you answered YES to any of the above or have a condition not listed, please explain and list medications:_____
_____
_____
_____

Doctor's Signature:_____ **Date:**_____