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, vitamins, and OTC medications):

_____

_____

_____

List any major injuries, surgeries,or hospitalizations you have had in the last 5 years (If none please write N/A):

_____

_____

Have you had an issue with any of the following: Crossed Eyes, Lazy Eye, Drooping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataract, Eye Infections, or any Eye Injuries? If none please write N/A; if yes, please circle which one(s) and explain:

_____

_____

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.

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, how often/amount:_____
Do you use tobacco products? No____ Yes____ If yes, how often/amount:_____
Do you use marijuana products? No____ Yes____ If yes, how often/amount:_____

Review of Systems

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

System:	NO	YES	?
CONSTITUTIONAL			
Sudden weight loss/gain	____	____	____
INTEGUMENTARY(Skin Issues)	____	____	____
NEUROLOGICAL			
Headaches	____	____	____
Migraines	____	____	____
Seizures	____	____	____
EYES			
Loss of Vision/Blindness	____	____	____
Blurred Vision	____	____	____
Cloudy/Halo Vision	____	____	____
Loss of Side Vision	____	____	____
Double Vision	____	____	____
Diabetic	____	____	____
Mucus Discharge	____	____	____
Chronic Redness	____	____	____
Sandy/Gritty Feeling	____	____	____
Itching	____	____	____
Burning	____	____	____
Foreign Body Sensation	____	____	____
Excessive Watering/Tearing	____	____	____
Glare/Light Sensitivity	____	____	____
Eye Pain/Soreness	____	____	____
Chronic Infection of Eyelid	____	____	____
Recurring Chalazion (Cyst)	____	____	____
Flashes/Floaters in Vision	____	____	____
Eye Strain/Fatigue	____	____	____
ENDOCRINE			
Thyroid/Gland Issues	____	____	____
Lymph Node Issues	____	____	____

System:	NO	YES	?
EARS/NOSE/MOUTH/THROAT			
Allergies/Hay Fever	____	____	____
Sinus Issues	____	____	____
Post- Nasal Drip	____	____	____
Chronic Cough	____	____	____
Dry Throat/Mouth	____	____	____
Vertigo	____	____	____
RESPIRATORY			
Asthma	____	____	____
Chronic Bronchitis	____	____	____
Emphysema	____	____	____
VASCULAR/CARDIOVASCULAR			
Poor Circulation	____	____	____
Heart Pain	____	____	____
High Blood Pressure	____	____	____
Vascular Disease	____	____	____
GASTROINTESTINAL			
Diarrhea	____	____	____
Constipation	____	____	____
Ulcers	____	____	____
GENITOURINARY			
Kidney/Bladder Issues	____	____	____
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	____	____	____
Joint Pain	____	____	____
Muscle Pain	____	____	____
LYMPHATIC/HEMATOLOGIC			
Anemia	____	____	____
ALLERGIC/IMMUNOLOGIC	____	____	____
PSYCHIATRIC	____	____	____

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

_____

_____

_____

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