Medical History Questionnaire

Name: _____ Today's Date: _____

If a Child, Parent's Name: _____ School Grade: _____

Birth Date: _____ Social Security # _____ Last Eye Exam: _____

Address: _____ City: _____ State, Zip: _____

Phone: _____ Work Phone: _____ Employed By: _____

MEDICAL HISTORY

Referred By: _____

Medical Doctor's Name _____ Last Medical Exam: _____

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain? _____

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medication and home remedies)

_____

_____

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

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease 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 contact lenses? ☐ NO ☐ YES If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ YES ☐ NO

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	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes/Lazy Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with doctor

☐ Yes, I would prefer to discuss this information with my doctor. (Check box)

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 use illegal drugs? ☐ NO ☐ YES If yes, type/amount/how long: _____

Do you drink alcohol? ☐ NO ☐ YES If yes, type/amount/how long: _____

Have you ever been exposed to, or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO