

Medical History Questionnaire

Name: _____ Today's Date: ____/____/____
 Address: _____ Place of Employment: _____
 _____ Work Phone: _____
 Phone: _____ Last Eye Exam: ____/____/____
 Birth Date: ____/____/____ Social Security#: ____/____/____ Dr.'s Phone: _____
 Name of Medical Doctor: _____ Last Medical Exam: ____/____/____

How did you hear about our office: Friend Relative Newspaper Ad Other

If referred, by whom: _____

Medical History

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

List any medications you take (including oral contraceptives, aspirin, over the counter medications 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 | <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