

Medical History Questionnaire

Please complete the **BOTH SIDES** of this questionnaire to help your doctor determine your risk for eye health problems and help you see better. All information is kept strictly confidential.

Name _____ Today's Date ____/____/____

Occupation _____ Do you use a computer? Yes No

Last Eye Exam (if elsewhere) ____/____/____ with Dr. _____

Your Medical Doctor _____ Last Medical Exam ____/____/____

Are you allergic to any medications? Yes No If yes, what? _____

What medications do you currently take (including aspirin, oral contraceptives, over the counter medications and eye drops)? _____

What major injuries and surgeries have you had (including eye injury and surgery)?

If female, are you pregnant or nursing? Yes No

Do you have prescription glasses? Yes No If yes, how old are your present lenses? _____

Do you wear contact lenses? Yes No If yes, how old are your present lenses? _____

If no, are you interested in wearing contact lenses? Yes No

Are you interested in refractive surgery (LASIK)? Yes No

Do you drive? Yes No

If yes, do you have any visual difficulty when driving? Yes No

Do you use tobacco products? Yes No If yes, list type/amount/how long _____

Do you drink alcohol? Yes No If yes, list type/amount/how long _____

Do you use illegal drugs? Yes No If yes, list type/amount/how long _____

Family History

Do any of your blood relatives (parents, grandparents, or siblings, living or deceased) have the following:

<u>Disease/Condition</u>	<u>Yes</u>	<u>No</u>	<u>If yes, then relationship to you</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

→→ **Please turn form over and complete side two** ←←

Your Medical History

**Do YOU now have any of the following?
Please check "yes" or "no" for each condition.**

EYES

- Blurred Vision
- Distorted Vision
- Loss of Side Vision
- Double Vision
- Dryness of Eyes
- Sandy or Gritty Feeling
- Redness of Eyes
- Itchy Eyes
- Burning/Stinging
- Watering/Excess Tearing
- Glare/Light Sensitivity
- Flashes or Floaters in Vision

YES	NO

Do YOU now have or in the past have you had any of the following?

EYES

- Crossed Eyes
- Lazy Eye
- Glaucoma
- Retinal Detachment
- Retinal Disease
- Cataracts
- Eye Surgery

YES	NO

MUSCULOSKELETAL

- Rheumatoid Arthritis
- Joint Pain

NEUROLOGICAL

- Multiple Sclerosis
- Headaches
- Migraines
- Seizures

ENDOCRINE

- Thyroid
- Grave's Disease

Diabetes

EARS, NOSE, MOUTH, THROAT

- Sinus Problems
- Chronic Cough
- Dry Throat/Mouth

RESPIRATORY

- Asthma
- Emphysema/COPD
- Tuberculosis

ALLERGIC/IMMUNOLOGIC

- Hay Fever/Allergies
- Lupus
- HIV/AIDS

CARDIOVASCULAR

- Heart Attack
- Other Heart Problems
- High Blood Pressure
- Stroke
- Circulatory Problems

GASTROINTESTINAL

- Intestinal/Bowel Problems

GENITOURINARY

- Kidney Disease
- Hepatitis
- Syphilis

SKIN

- Skin Condition

HEMATOLOGICAL/LYMPHATIC

- Anemia
- Bleeding Problems
- Cancer

PSYCHIATRIC

- Depression
- Anxiety
- Mental Illness

YES	NO

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Please list any other medical conditions you have or give details regarding above conditions:

Thank you!

FOR OFFICE USE ONLY

_____, O.D. ____/____/____

_____, O.D. ____/____/____

_____, O.D. ____/____/____

_____, O.D. ____/____/____