Medical History Questionnaire

Please complete **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 _____ Todays Date _____/_____/_____

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)? Please include dates.

_____

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

Disease/Condition	**Yes**	**No**	**If yes, relationship to you**
Blindness			
Cataract			
Crossed Eye/Lazy Eye			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Retinal Disease			
Cancer			
Diabetes			
High Blood Pressure			
Heart Condition			

Your Medical History

Do you have or have you ever had any of the following?

Eyes	Yes	No
Crossed Eye		
Lazy Eye		
Glaucoma		
Cataracts		
Retinal Disease		
Retinal Detachment		
Eye Surgery		
Allergic/Immunologic		
Hay Fever/Allergies		
Lupus		
HIV/AIDS		
Cardiovascular		
Heart Attack		
Other Heart Problems		
High Blood Pressure		
High Cholesterol		
Stroke		
Endocrine		
Diabetes		
Grave's disease		
Hypothyroidism		
Hyperthyroidism		
Gastrointestinal		
Acid Reflux		
Irritable Bowel		
Crohn's Disease		
Gall Bladders issues		
Hepatitis		
Genitourinary		
Kidney Disease		
Syphilis		
Bladder issues		

Ears, Nose, Mouth, Throat	Yes	No
Hearing Loss		
Chronic Cough		
Dry Throat/Mouth		
Hematological/Lymphatic		
Anemia		
Cancer		
Skin		
Eczema		
Psoriasis		
Musculoskeletal		
Osteoarthritis		
Rheumatoid Arthritis		
Neurological		
Multiple Sclerosis		
Headaches		
Migraines		
Seizures		
Fibromyalgia		
Psychiatric		
Depression		
Anxiety Disorder		
ADD/ADHD		
Bipolar disorder		
Schizophrenia		
Respiratory		
Asthma		
Emphysema		
COPD		
Tuberculosis		

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

_____

_____

For Office Use Only: _____, O.D. _____ / _____ / _____