Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Phone: _____

City: _____ Zip Code: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Email: _____ _____

Birth Date: _____ Social Security Number: _____

Gender: _____ Date of Last Medical Exam: _____

Name of Medical Doctor (PCP): _____ Dr's Phone: _____

Medical History

Do you have any current medical conditions? ❒ _____ ❒ _____ ❒ _____ ❒ _____ ❒ _____

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

_____

_____

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

_____

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

_____

Check any of the following that you have had: ❒ crossed eyes ❒ lazy eye ❒ drooping eye lid ❒ eye injury

❒ Glaucoma ❒ retinal disease ❒ cataracts ❒ eye infections

	No	Yes	
Are you pregnant or nursing?	❒	❒	
Do you wear glasses?	❒	❒	If yes, how old is your present pair of lenses? _____
Do you wear contact lenses?	❒	❒	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: 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 Eyed	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment or Disease	❒	❒	❒	
Arthritis	❒	❒	❒	

Disease/Condition	No	Yes	?	Relationship to You
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other	❒	❒	❒	

Please Turn This Form Over & Complete Side Two

Review of Systems: Do you currently have any of the following symptoms?

System	No	Yes	?
Neurological			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
Eyes			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing / Watering	❒	❒	❒
Glare / Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection, Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes, Floaters in Vision	❒	❒	❒

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

Doctor's Signature _____ Date: _____