

Medical History Questionnaire

(Please Print)

Name: _____

Today's Date: _____

Address: _____

Phone: _____

_____ ZIP _____

Work Phone: _____

SSN#: ____/____/____ Birth Date: ____/____/____

Employer: _____

Name of Medical Doctor: _____

Last Eye Exam: ____/____/____

Last Medical Exam: ____/____/____

Referred by: _____

Emergency Contact: _____

paper/radio/friend/relative/other

Parents (if minor): _____

Medical History

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

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/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 contacts? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Disposable Are they comfortable? no yes

Family History

Please note any family history (*self, 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"/>	_____
Cataracts	<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 over and complete side two